

Joslyn Cruz, Ph.D.

Licensed Psychologist



Client Welcome & Intake Form

Adolescent (14+)

Please complete as fully as possible. If a question does not apply or you'd prefer to discuss it in session, write "discuss."

ADOLESCENT INFORMATION

Full Name	Preferred Name	Pronouns	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Date of Birth	Age	School	Grade
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	City	State	Zip
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PARENT / GUARDIAN INFORMATION

Parent / Guardian Name(s)	Relationship to Adolescent	
<input type="text"/>	<input type="text"/>	
Phone	Email	Custody / Legal Decision-Making
<input type="text"/>	<input type="text"/>	<input type="text"/>

Contact preferences: OK to leave voicemail OK to text OK to email

Home Address (if different from adolescent)

Second Parent / Guardian (optional)	Relationship	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

Emergency Contact (if different)	Relationship	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

REASON FOR REFERRAL

What concerns led you to seek therapy for your child at this time?

When did these concerns begin?

PRIMARY CONCERNS

Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression / mood changes |
| <input type="checkbox"/> Irritability / anger | <input type="checkbox"/> Impulsivity or risk-taking |
| <input type="checkbox"/> Social difficulties | <input type="checkbox"/> School-related concerns |
| <input type="checkbox"/> Family conflict | <input type="checkbox"/> Excessive screen use / gaming |
| <input type="checkbox"/> Pornography use or sexual behavior concerns | <input type="checkbox"/> Self-injury |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Substance use concerns |

Other concerns

CURRENT FUNCTIONING

School:

- | | |
|---|--|
| <input type="checkbox"/> Doing well | <input type="checkbox"/> Struggling academically |
| <input type="checkbox"/> School refusal | <input type="checkbox"/> Behavioral issues |

School details

Social:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Has friends | <input type="checkbox"/> Difficulty making / keeping friends | <input type="checkbox"/> Social withdrawal |
|--------------------------------------|--|--|

Social details

Home behavior:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Frequent conflict |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Withdrawn |

Home details

SLEEP & EATING PATTERNS

- | | |
|---|---|
| <input type="checkbox"/> Sleep difficulties (onset, waking, restless) | <input type="checkbox"/> Oversleeping |
| <input type="checkbox"/> Appetite changes | <input type="checkbox"/> Disordered eating concerns |

Average hours of sleep / night

Notes

MEDICAL HISTORY & CURRENT PROVIDERS

Pediatrician / PCP Name

Phone

Psychiatrist / Prescriber (if any)

Phone

Current Medications (name, dose, frequency)

Known allergies

Significant medical conditions

I authorize Dr. Cruz to coordinate care with the providers listed above (Release of Information).

BEHAVIORAL & EMOTIONAL HEALTH

Please indicate any current concerns:

- | | |
|---|--|
| <input type="checkbox"/> Difficulty managing emotions | <input type="checkbox"/> Frequent anger or outbursts |
| <input type="checkbox"/> Anxiety or excessive worry | <input type="checkbox"/> Low mood or loss of interest |
| <input type="checkbox"/> Impulsive behaviors | <input type="checkbox"/> Risk-taking behaviors |
| <input type="checkbox"/> Perfectionism / self-criticism | <input type="checkbox"/> Difficulty with focus / attention |

Sexual behavior (if applicable):

- | | |
|--|---|
| <input type="checkbox"/> Excessive pornography use | <input type="checkbox"/> Secretive online behavior |
| <input type="checkbox"/> Boundary concerns | <input type="checkbox"/> Prefer to discuss in session |

Other (optional)

SAFETY & RISK

Has your child ever:

- Talked about wanting to die or not be here
- Engaged in self-injury
- Made a suicide attempt
- Shown aggression toward others

If yes, please describe (timing, frequency, current status):

SUBSTANCE USE SCREENING

Does your child currently or recently use any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cannabis / THC |
| <input type="checkbox"/> Nicotine / vaping | <input type="checkbox"/> Prescription misuse |
| <input type="checkbox"/> Other substances | <input type="checkbox"/> None known |

Details (frequency, context, concerns)

DEVELOPMENTAL & DIAGNOSTIC HISTORY

Previously diagnosed with:

- | | |
|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Autism Spectrum Disorder |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Depressive disorder |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Trauma-related |
| <input type="checkbox"/> None | <input type="checkbox"/> Other |

Relevant developmental history (early milestones, social development, trauma history, etc.):

FAMILY MENTAL HEALTH HISTORY

Any history of mental health conditions, substance use, or suicide in biological relatives?

PREVIOUS TREATMENT

Has your child previously received therapy, counseling, or psychiatric care? What was helpful or not helpful?

PARENT PERSPECTIVE

What do you feel your child needs most right now?

What would improvement look like in 3–6 months?

What strategies have you already tried?

ADOLESCENT VOICE (TO BE COMPLETED BY TEEN, IF APPROPRIATE)

What do you think is the main problem (if any)?

What would you want to be different?

FINANCIAL INFORMATION (PRIVATE-PAY PRACTICE)

This is a private-pay practice. The fee is **\$250 per 50-minute session**, due at the time of service. Upon request, Dr. Cruz will provide a monthly **superbill** for possible out-of-network reimbursement; reimbursement is determined by your insurance plan and is not guaranteed.

Accepted forms of payment: cash, check, credit card, HSA, FSA, and Zelle.

Name on Card / Account Holder

Preferred Payment Method

CANCELLATION POLICY

Sessions cancelled with less than **24 hours' notice**, or missed without notice, are charged the full session fee.

I have read and agree to the cancellation policy above.

TELEHEALTH CONSENT

Dr. Cruz offers telehealth sessions to clients physically located in **Connecticut, New York, or Michigan** at the time of session. The client (and guardian, where applicable) agrees to participate from a private, quiet location and to confirm their physical address at the start of each telehealth session. Technology limitations, privacy risks, and the possibility of switching to in-person or phone sessions have been explained. In a safety emergency, Dr. Cruz may contact local emergency services at the client's location.

I consent to receive telehealth services under the conditions described above.

SIGNATURES

Parent / Guardian Printed Name

Date

Parent / Guardian Signature

Adolescent Printed Name (assent, 14+)

Date

Adolescent Signature (assent)

Clinician Signature — Joslyn Cruz, Ph.D.

Date