The Wake Kendall Group PLLC

Psychological & Educational Services

Internal use only
Date received:

Phone screen scheduled (day, time):

Please send your completed form to us by mail or fax:

Attn: DBT Program
The Wake Kendall Group PLLC
5247 Wisconsin Ave NW, Suite 4
Washington, DC 20015

Fax: 202-362-9633

APPLICATION FOR ADOLESCENT DBT PROGRAM

Thank you for your interest in The Wake Kendall Group's Dialectical Behavior Therapy program. Please refer to the DBT section of our website (www.wakekendall.com) for more information about our DBT program and intake procedure. Once we receive your application, we will give you a call within a few days.

Upon request, we can email a brief summary of fees and financial policies to the address you provide on this form. If a family member will be paying for your therapy, we encourage you to forward this information along to that person in advance of your intake appointment. We request that you refrain from communicating electronically beyond this initial exchange.

Name of Adolescent: _____

Names of Parent(s): _____

Parent phone numbers: *indicate preferred number(s) with an asterisk (*)*

Home _____

Office _____

Cell _____

Adolescent's phone number: _____

Parent e-mail address: _____

Referral Source: _____

Age_____ Grade _____ School: _____

How is he/she doing in school?

_____

_____

_____

What is he/she struggling with (generally speaking)?

_____

_____

_____

Does he/she engage in self-harming behaviors (e.g. cutting, alcohol and drug use, binging, purging, restricted eating, promiscuity, unsafe sex)?

_____

_____

_____

Does he/she think about suicide? Any gestures? Any attempts?

_____

_____

_____

Has he/she ever participated in any day treatment and/or hospitalization programs? If so, please give the date(s) and reasons for intensive treatment.

_____

_____

_____

Has he/she ever suffered from unusual perceptions, hallucinations, disordered thinking, delusions, and/or significant paranoia?

_____

_____

_____

Current diagnoses (to the best of knowledge):

_____

_____

_____

Current medications:

_____

_____

Does your adolescent take his/her medications consistently?

_____

Prescribing psychiatrist (if applicable):

_____

Current psychotherapist (if applicable):

_____

Has he/she has been in therapy before? If yes, with whom, and when? How have those treatments gone?

_____

_____

_____

What strengths does your adolescent possess?

_____

_____

_____