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 ADULT 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 Applicant: _____

Phone number(s): *indicate preferred number with an asterisk (*)*

Home _____

Office _____

Cell _____

Email address: _____

Age:_____ Education level _____

How did you learn about our program? _____

Briefly describe your weekly commitments (e.g. full-time or part-time work, volunteer work, classes, family/friend obligations, hobbies, etc.).

_____

_____

_____

Briefly describe what you are struggling with and/or the goals that you want to pursue with the help of our DBT program.

_____

_____

_____

Briefly describe any self-harming behaviors you have engaged in during the past year.

_____

_____

_____

Suicide Ideation: Within the last year, I have thought about killing myself…

Never / Sometimes / A lot

Suicide Gestures/Attempts: I have taken steps to kill myself…

Never / Sometimes / A lot

Have you ever participated in any day treatment and/or hospitalization programs for mental health issues? If so, please give the date(s) and reasons for intensive treatment.

_____

_____

_____

Have you ever suffered from unusual perceptions, hallucinations, disordered thinking, delusions, and/or significant paranoia? If so, please describe briefly.

_____

_____

_____

Current diagnoses (to the best of your knowledge):

_____

_____

Current medications:

_____

_____

What is the frequency with which you take your prescribed medications?

All of the time / Sometimes / Never

Explain (if needed)

_____

_____

Prescribing psychiatrist (if applicable):

_____

Current psychotherapist (if applicable):

_____

Describe any additional professional support networks, if applicable (i.e. doctors, support groups, etc.).

_____

_____

_____

Please give us a sense of your schedule and availability - circle and/or rank times when you could come in for group skills training:

Tuesday (9:30am - 11:15am)

Wednesday (10:00am - 11:45am)

Thursday (10:30am - 12:15pm)

Thursday (5:30pm - 7:15pm)

Please describe your availability to come in for individual therapy. Note that none of our therapists works on the weekends. Some therapists offer early morning and/or early evening appointments.

_____

_____

_____