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CHILD / ADOLESCENT INTAKE FORM

Today's date: ____________________

Patient Information:

Name: _______________________________________ Date of Birth: ____________ Age: ______ Gender:

M / F Ethnicity (Optional) ____________________________

Patient Contacts:

Mother's Name: ____ Age: ______________

Father's Name: ____ Age: ______________

Marital Status of Parents: (circle) Married Divorced Separated Widowed

Mother's Address:____

(Street) (City) (State) (Zip)

Contact phone number(s): ____

Father's Address: ____

(Street) (City) (State) (Zip)

Contact phone number(s):____

Who has legal custody?____ Type: _____________

Who has physical custody?____ Type: _____________

Referral Information:

Who referred you to this practice?

____

(Name) (Phone)

____

(Address)

Presenting Problem:____

____

____

What concerns you most about your child?

____

____

____

When did you first notice this problem?

____

____

____

How has this problem affected his/her function?

At home: ____

____

At school/work: ____

____

Community: ____

____

Do you have other concerns that you would like addressed?

____

____

What are your goals/expectations for treatment?

____

____

____

____

Have you recently worried that your child has (PLEASE CIRCLE ITEMS RELEVANT TO YOUR CHILD):

Yes No DEPRESSION (sad, irritable, hopeless, helpless, difficulty sleeping, crying, sleeping too much, decreased energy/fatigue, feelings of worthlessness or guilt, difficulty thinking or concentrating, difficulty making decisions, social withdrawal/isolative behaviors, lack of interest in things, suicidal thoughts, etc.)

Yes No MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)

Yes No ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)

Yes No BEHAVIORAL PROBLEM (fights/physical aggression, anger, arguing, truancy, destruction of property, fire setting, etc.)

Yes No ATTENTION / HYPERACTIVITY PROBLEM (difficulty paying attention, easily distracted, difficulty completing tasks, hyperactive, impulsive)

Yes No ABNORMAL EATING BEHAVIORS (too much/significant weight gain, too little/significant weight loss, fear of weight gain, distorted body image, excessive exercising, etc.)

Yes No SOCIAL ANXIETY (shy and/or afraid to be around others, avoidance of crowds, avoidance of public places)

Yes No REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)

Yes No AUTISM (social and language impairments, rigidity)

Yes No PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

Yes No DISSOCIATION (feeling outside your body or things are not real, etc.)

Yes No Has your child ever harmed themselves intentionally? Attempted suicide? Harmed others? If yes, please explain.

____

____

____

Past Psychiatric History:

PREVIOUS PSYCHIATRIC HOSPITALIZATIONS for your child (residential or day treatment programs, including any alcohol and drug treatment programs):

____

____

____

Diagnosis When (month/year) Length of Stay Treatment of Where

____

____

____

CURRENT or PAST PSYCHIATRIST AND THERAPISTS for your child (include name, location, dates and length of treatment):

____

____

____

CURRENT PSYCHIATRIC MEDICATIONS for your child:

Name Highest Dosage Duration Response Reason for Stopping

____

____

____

____

PAST PSYCHIATRIC MEDICATIONS for your child (if greater than 4 medications, please attach separate list):

Name Highest Dosage Duration Response Reason for Stopping

____

____

____

____

Family History:

Consider this individual's immediate family and all of their relatives on both sides (parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins) Review the list below - if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Uncle") and their treatment history (if applicable). Maternal is mother's side of the family and paternal is father's side of the family.

_____ Depression ____

_____ Anxiety ____

_____ ADHD ____

_____ Bipolar (manic depressive) ____

_____ Schizophrenia ____

_____ Alcohol Problems ____

_____ Drug Problems ____

_____ Learning Disabilities ____

_____ Autism / Asperger's /Pervasive Developmental Disorder ____

_____ Mental Retardation ____

_____ Nervous Breakdown ____

_____ Psychiatric Hospitalizations ____

_____ Suicide attempts ____

_____ Completed suicide ____

_____ Panic Disorder ____

_____ PTSD (Post Traumatic Stress Disorder) ____

_____ OCD (Obsessive Compulsive Disorder) ____

_____ Seizures ____

_____ Migraines ____

_____ Heart or lung problems ____

_____ Thyroid ____

_____ Immunological disorders (lupus, scleroderma, inflammatory bowel disease) _________________________

_____ Cancer ____

_____ Other ____

<u>Past Medical History:</u>

Primary Care Provider: ______________________________________ Phone: ____________________

Address: ____

Drug Allergies and Reaction: ____

____

Has your child ever had any:

- ▯ Loss of Consciousness
- ▯ Head Injury
- ▯ Seizures
- ▯ Does your child have any of the following:
- ▯ High blood pressure
- ▯ Diabetes
- ▯ Arthritis
- ▯ Back or neck pain
- ▯ Asthma
- ▯ COPD/Emphysema
- ▯
- ▯ Heart problems
- ▯ Heart murmur
- ▯ Stroke
- ▯ Thyroid problems
- ▯ Stomach Ulcer
- ▯ GERD (acid reflux)
- ▯ Liver disease
- ▯ Kidney Problems
- ▯ Menstrual Problems
- ▯ Cancers
- ▯

If yes for cancers, what type and any required treatment?

____

____

If yes for surgeries, what type?

____

____

Any other medical problems not listed above? If so, please list here:

____

____

____

CURRENT NON-PSYCHIATRIC MEDICATIONS:

Name Dosage Duration Response

____

____

____

____

____

Pregnancy and Birth History:

How old was this child's biological parents when he/she was conceived? ______________________________

Baby's birth weight and length: ____

Length of pregnancy (in weeks): ____

Did you take any medication (prescription and over the counter) during this pregnancy?

(If yes, please complete the following table.)

Medication	Month(s) Taken (1-9)	Reason for Taking

Did you consume alcohol during this pregnancy? __________ If yes, how much and how often?

____

Did you smoke or use tobacco products during this pregnancy? _______ If yes, how much and how often?____

Did you use any drugs during this pregnancy? ________ If yes, please name drug(s), how much, and how often used:

____

____

____

Labor Information

Were there any problems with the baby's health right before or immediately after delivery? ______________________

If yes, please describe: ____

____

____

Apgar Scores: ____

Developmental History:

At what age did your child achieve the following milestones?

__________ Language (age at first using words, sentences, etc.)

__________ Fine Motor Skills (building towers with cubes, drawing circle)

__________ Gross Motor Skills (rolling over, standing, walking) __________

Toilet training

Has your child experienced any regression of these? ________

If yes, explain:

____

____

Substance Abuse History

Please indicate any substances used currently or in the past:

- ☐ Current Past
- ☐ Smoking Cigarettes (How much____________, How long___________)
- ☐ Alcohol (How much__________, How long___________)
- ☐ Marijuana
- ☐ Cocaine/Crack
- ☐ Ecstasy
- ☐ Huffing (gas, aerosol)
- ☐ Prescription Drugs

Did your child ever attend substance abuse treatment? If yes, please explain (where, when, treatment of):

____

____

____

School:

Where does your child attend school? ____

In what grade level is he/she? ____

What are his/her typical grades? ____

What are your child's academic strengths? ____

____

Academic weaknesses? ____

____

Has there been a change in your child's performance at school? ______ If yes, please describe: ______________________

____

____

Has your child received IQ or Academic Testing? _____ If yes, what were the results? _____________________________

____

____

Does or has your child participated in any of the following?

Yes No Resource (for which classes/how many hours?): _____________________________________

Yes No Accelerated or Honors programs, explain: ____

Yes No 504 Plan, explain: ____

Yes No Individual Education Plan (IEP), explain: ____

Has your child had problems with any of the following?

Yes No Truancy, explain: ____

Yes No Fights, explain: ____

Yes No Absenteeism, explain: ____

Yes No Detention, explain: ____

Yes No Suspension, explain: ____

Yes No School refusal, explain: ____

Peers:

Does your child have quality relationships with other children? ______ If no, please explain: ________________________

____

____

Has your adolescent had a recent change in friendships? ______ If yes, what changes, if any, are concerning you?

____

____

____

Do you have any concerns regarding your child's friendships? __________ (Please circle all that apply)

-Too Old -Too Young -Truant -Gang Fringe -Drug/Alcohol -use Violence -Too Many -Too Few -Sexual Promiscuity

-Too much time together -Other: ____

Are you concerned about your child's sexual activities? ____

Is your child sexually active? ____

Does your adolescent have a job? ____

Abuse History:

Has your child ever been the VICTIM OF ABUSE OR NEGLECT? _______ If yes, what was the nature of the abuse?

____

____

____

Has your child ever been involved with the following and, if yes, please explain:

Yes No Child Protective Services: ____

Yes No Probation / Juvenile Probation / Detention: ____

Yes No Has your adolescent's behavior ever resulted in police, detention, or court involvement? _______________

____

____

Yes No Head Start: ____

Yes No Early Intervention Services (ages 0-3): ____

Social History:

Is your child your biological child? ____________________

If no, at what age was he/she adopted? ____________________

Is there any contact with their biological parents? ____

Where was your child born and raised? ____

Parents: (including stepmother and stepfather, if applicable)

Name Age Lives at Home? Relation to Child

____

____

____

____

Culture:

Do you have a religious preference in the household? ________ If yes, what is that preference? ____________________

Has your child experienced any problems related to race, religion, or culture? _________ If yes, please explain:

____

____

____

Is there anything else you would like us to know about your child? ____

____

____

____

____