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CHILD / ADOLESCENT INTAKE FORM

Today's date:_____

Patient Information:

Name:_____ Date of Birth:_____ Age:____
(first) (last)

Gender M/F Ethnicity (Optional)_____

Patient Contacts:

Mother's name:_____ Age:____
(first) (last)

Father's name:_____ Age:____
(first) (last)

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/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 you want 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, poor sleep, crying, social withdrawal / isolative behaviors, lack of interest in things, 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, anger, arguing, truancy, destruction of property, fire setting, etc.)

☐ Yes ☐ No ATTENTION / HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)

☐ Yes ☐ No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc)

☐ Yes ☐ No SOCIAL ANXIETY (shy and/or afraid to be around others)

☐ 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?_____
_____
_____

Past Psychiatric History:

Please list any previous psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs)

Diagnosis *Length of Stay* *Treatment* *Response*

_____

_____

_____

Please list any current or prior outpatient psychiatrists and therapists your child has seen

Name *Title* *Location* *How long?*

_____

_____

_____

Please list your child's current psychiatric medications:

Name *Dosage* *Duration* *Response*

_____

_____

_____

Please list his / her current non-psychiatric medications:

Name *Dosage* *Duration* *Response*

_____

_____

_____

Please list all the psychiatric medications that have been tried in the past (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_____

(Family History cont.)

___Alcohol / Drug Problems_____

___Learning Disabilities_____

___Autism / Aspergers / Pervasive Developmental Disorder_____

___Mental Retardation_____

___Nervous Breakdown_____

___Psychiatric Hospitalizations_____

___Suicide (or attempts)_____

___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_____

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:_____

_____

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, please describe how much and how often? _____

Did you use any drugs during this pregnancy? _____ If yes, please name drug(s), how much and frequency of use: _____

_____

_____

Labor Information:

Were there any problems with the baby's health right before or immediately after delivery? _____ If yes, please describe: _____

_____

Apgar Scores: _____

Past Medical History:

Primary Care Provider: _____ Years Involvement: _____

Phone: _____

Address: _____

Approximate Date of Last Visit: _____

Number of Visits in Last Year: _____

Other Provider(s): _____

Specialty: _____

Name: _____ Phone: _____

Address: _____

Other Provider(s): _____

Specialty: _____

Name: _____ Phone: _____

Address: _____

Drug Allergies? _____ If yes, please name and describe your child's reaction: _____

_____

Has your child ever experienced a head injury, loss of consciousness, or seizure? _____

If yes, please describe: _____

_____

Does your child have any chronic medical problems? _____ If yes, please describe: ___

_____

Does your child have a history of any serious injuries or medical hospitalizations? _____

If yes, please describe: _____

_____

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? _____ If yes, please describe: _____

_____

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 Step-Mother and Step-Father, if applicable)

Name *Education* *Occupation* *Relationship with Child (quality)*

_____

_____

_____

_____

Please list the other children in the family and other household members who may also be living in your home:

Name *Age* *Lives at Home?* *Relation to Child* *Relationship with Child*

_____

_____

_____

_____

Abuse History:

Has your child ever been the victim of abuse or neglect? _____ If yes, what was the nature of the abuse? _____

_____

_____

Are you struggling with your marital relationship or parenting? _____ If yes, please describe: _____

_____

_____

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 Head Start: _____

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

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: _____

_____

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: _____

_____

TEEN / YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent'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: _____		

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

_____

Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? _____ If yes, please describe: _____

_____

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

Is your adolescent sexually active? _____

Does your adolescent have a job? _____

Has your adolescent's behavior ever resulted in police, detention, or court involvement? _____ if yes, please explain: _____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____