



**CHILD/ADOLESCENT INTAKE FORM**

**PATIENT INFORMATION**

Name: \_\_\_\_\_  
First Last  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street City State Zip

**PARENT CONTACTS**

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
First Last  
 Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
First Last

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

Mother's Address: \_\_\_\_\_  
Street City State Zip

Contact phone number(s): \_\_\_\_\_  
Home Cell Work

Father's Address: \_\_\_\_\_  
Street City State Zip

Contact phone number(s): \_\_\_\_\_  
Home Cell Work

If divorced, who has legal custody? \_\_\_\_\_  
 Who has physical custody? \_\_\_\_\_  
 What is the schedule for parenting time? \_\_\_\_\_  
 \_\_\_\_\_

**REFERRAL INFORMATION**

Who referred you to this practice? \_\_\_\_\_  
(Name)  
 \_\_\_\_\_  
(Address)  
 \_\_\_\_\_  
(Phone) Fax)

**PRESENTING PROBLEM**

What is the **PROBLEM** for which you are seeking assistance for your child/adolescent? \_\_\_\_\_

\_\_\_\_\_

What concerns you most about your child/adolescent? \_\_\_\_\_

\_\_\_\_\_

When did you first notice this problem? \_\_\_\_\_

What caused you to seek assistance at this time? \_\_\_\_\_

How has this problem affected his/her functioning? At home: \_\_\_\_\_

At school/work: \_\_\_\_\_

In the 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/adolescent has any of the following? **(IF YES, PLEASE CIRCLE EACH INDIVIDUAL ITEM THAT IS RELEVANT TO HIM/HER.)**

Yes  No **DEPRESSION** (sad, irritable, hopeless, helpless, crying, difficulty sleeping, 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)

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 / work absences, etc.)

Yes  No **BEHAVIORAL PROBLEMS** (fights/physical aggression, anger, arguing, destruction of property, fire setting, hurting animals, etc.)

Yes No **ATTENTION / HYPERACTIVITY PROBLEMS** (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, fear of being judged by 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 his/her body or like things are not real, etc.)

Yes No Has your child/adolescent ever **HARMED HIM/HERSELF INTENTIONALLY**? If yes, please explain: \_\_\_\_\_

Yes No Has your child/adolescent ever **ATTEMPTED SUICIDE**? If yes, please explain: \_\_\_\_\_

Yes No Has your child/adolescent ever **HARMED OTHERS**? If yes, please explain: \_\_\_\_\_

Yes No Has your child/adolescent ever been the **VICTIM OF ABUSE OR NEGLECT**? If yes, what was the nature of the abuse/neglect? \_\_\_\_\_

Yes No Has your child/adolescent experienced a **SIGNIFICANT LOSS**? If yes, please explain: \_\_\_\_\_

Yes No Has your child/adolescent experienced any **PROBLEMS RELATED TO RACE, RELIGION, OR CULTURE**? If yes, please explain: \_\_\_\_\_

Has your child/adolescent ever been involved with the following? If yes, please explain:

Yes No Child Protective Services: \_\_\_\_\_

Yes No Probation / Juvenile Probation / Detention / Police: \_\_\_\_\_

**MENTAL HEALTH HISTORY**

**OUTPATIENT TREATMENT** for your child/adolescent:

<u>Name</u>	<u>Location</u>	<u>When (month/year)?</u>	<u>For how long?</u>
Psychiatrist: _____			
_____			

Therapist: _____			
_____			

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

<u>Where</u>	<u>When (month/year)</u>	<u>Length of Stay</u>	<u>Type of Treatment</u>	<u>Diagnosis</u>
_____				
_____				

**CURRENT PSYCHIATRIC MEDICATIONS** for your child/adolescent:

<u>Name</u>	<u>Dosage</u>	<u>When Prescribed</u>	<u>Prescribed By</u>	<u>Response</u>
_____				
_____				

**PREVIOUS PSYCHIATRIC MEDICATIONS** for your child/adolescent (if greater than 6 medications, please attach separate list):

<u>Name</u>	<u>Highest Dosage</u>	<u>Duration</u>	<u>Response</u>	<u>Reason for Stopping</u>
_____				
_____				

**SUBSTANCE USE** of your child/adolescent:

	<u>Type</u>	<u>Average Usage</u>	<u>Current</u>	<u>Past</u>	<u>When Last Used</u>
Caffeine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nicotine	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marijuana	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Type	Average Usage	Current	Past	When Last Used
Inhalants	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hallucinogens (LSD/Ecstasy/PCP/Mushrooms)	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Opiates (Heroin/Morphine/Other Narcotics)	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sedatives	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Steroids	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stimulants (Meth/Crack/Cocaine/Crank)	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Synthetic Drugs/Bath Salts	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Misuse of Other Prescription Drugs	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**PREGNANCY AND BIRTH HISTORY**

How old were 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: \_\_\_\_\_

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 (first using words, sentences, etc.)? \_\_\_\_\_
- \_\_\_\_\_ Fine Motor Skills (building towers with cubes, drawing circles)? \_\_\_\_\_
- \_\_\_\_\_ Gross Motor Skills (rolling over, standing, walking)? \_\_\_\_\_
- \_\_\_\_\_ Daytime Toilet training? \_\_\_\_\_
- \_\_\_\_\_ Nighttime Toilet training? \_\_\_\_\_

Has your child experienced any regression of these? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

Is your child/adolescent your biological child? \_\_\_\_\_ If no, at what age was he/she adopted? \_\_\_\_\_

Is there any contact with his/her biological parents? \_\_\_\_\_

Where was your child/adolescent born and raised? \_\_\_\_\_

**FAMILY MEMBERS:** (including parents, stepparents, siblings, stepsiblings and half-siblings)

Name	Age	Lives at Home?	Relation to Child	Quality of Relationship with Child
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who disciplines your child & what kind of discipline is used? \_\_\_\_\_

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

Do you have an ethnic heritage that is an influence on your child's life? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

**SCHOOL:**

Where does your child/adolescent 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? \_\_\_\_\_

Has your child participated in any of the following? If yes, please explain:

Yes  No Resource Room (for which classes/how many hours?) \_\_\_\_\_

Yes  No Gifted, Accelerated, or Honors programs \_\_\_\_\_

Yes  No 504 Plan: \_\_\_\_\_

Yes  No Individual Education Plan (IEP): \_\_\_\_\_

Yes  No Head Start: \_\_\_\_\_

Yes  No Early Intervention Services (ages 0-3) or Birth through Five: \_\_\_\_\_

Has your child had problems with any of the following? If yes, please explain:

Yes  No Truancy \_\_\_\_\_

Yes  No Fights \_\_\_\_\_

Yes  No Absenteeism \_\_\_\_\_

Yes  No Detention \_\_\_\_\_

Yes  No Suspension \_\_\_\_\_

Yes  No School refusal \_\_\_\_\_

**PEERS:**

Does your child/adolescent have quality relationships with other children/adolescents? \_\_\_\_ If not, please explain: \_\_\_\_\_

Has your child/adolescent had a recent change in friendships? \_\_\_\_ If yes, what changes, if any, are of concern to you? \_\_\_\_\_

Do you have any concerns regarding your child/adolescent's friendships?

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> Too Old   | <input type="checkbox"/> Too much time together | <input type="checkbox"/> Drug/Alcohol Use   |
| <input type="checkbox"/> Too Young | <input type="checkbox"/> Truant                 | <input type="checkbox"/> Violence           |
| <input type="checkbox"/> Too Many  | <input type="checkbox"/> Gang                   | <input type="checkbox"/> Sexual Promiscuity |
| <input type="checkbox"/> Too Few   | <input type="checkbox"/> Fringe                 | <input type="checkbox"/> Other: _____       |

Is your child/adolescent sexually active? \_\_\_\_ If yes, are you concerned about your child/adolescent's sexual activities? \_\_\_\_\_

Does your adolescent have a job? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

What are your child/adolescent's hobbies/interests? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY**

Consider your child's immediate family and all of his/her relatives on both sides. (Maternal is mother's side of the family and Paternal is father's side of the family.) Include parents, brothers, sisters, aunts, uncles, grandparents, and 1<sup>st</sup> cousins. Review the list below. If any relative has one of these disorders, check it and describe his/her relation to your child/adolescent and his/her treatment history (if applicable).

\_\_\_\_\_ Depression \_\_\_\_\_

\_\_\_\_\_ Anxiety \_\_\_\_\_

\_\_\_\_\_ ADHD \_\_\_\_\_

\_\_\_\_\_ Bipolar (manic depressive) \_\_\_\_\_

\_\_\_\_\_ Schizophrenia \_\_\_\_\_

\_\_\_\_\_ Alcohol Problems \_\_\_\_\_

\_\_\_\_\_ Drug Problems \_\_\_\_\_

\_\_\_\_\_ Learning Disabilities \_\_\_\_\_

\_\_\_\_\_ Autism / Asperger's /Pervasive Developmental Disorder \_\_\_\_\_

\_\_\_\_\_ Mental Retardation/Intellectual Disability \_\_\_\_\_

\_\_\_\_\_ Nervous Breakdown \_\_\_\_\_

\_\_\_\_\_ Psychiatric Hospitalizations \_\_\_\_\_

\_\_\_\_\_ Suicide attempts \_\_\_\_\_

\_\_\_\_\_ Completed suicide \_\_\_\_\_

\_\_\_\_\_ Panic Disorder \_\_\_\_\_

\_\_\_\_\_ PTSD (Post Traumatic Stress Disorder) \_\_\_\_\_

\_\_\_\_\_ OCD (Obsessive Compulsive Disorder) \_\_\_\_\_

\_\_\_\_\_ Seizures \_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_

**MEDICAL HISTORY**

**PRIMARY CARE PROVIDER** \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

When was his/her last physical exam with bloodwork? \_\_\_\_\_

Are there other physicians/specialists your child sees on a regular basis? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



**CHECK IF YOUR CHILD/ADOLESCENT HAS EVER HAD:**

- Loss of Consciousness                       Head Injury                       Seizures

**CHECK IF YOUR CHILD/ADOLESCENT HAS ANY OF THE FOLLOWING:**

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> High Cholesterol                   |
| <input type="checkbox"/> Anemia/ Low Iron         | <input type="checkbox"/> IBS/Crohn's Disease/Celiac Disease |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Kidney Disease                     |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Liver disease                      |
| <input type="checkbox"/> Bedwetting/Toilet Issues | <input type="checkbox"/> Menstrual Problems                 |
| <input type="checkbox"/> Back or Neck Pain        | <input type="checkbox"/> Migraine Headaches                 |
| <input type="checkbox"/> Chronic Nosebleeds       | <input type="checkbox"/> Obesity                            |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Skin Conditions/Eczema/Dermatitis  |
| <input type="checkbox"/> Hearing Problem          | <input type="checkbox"/> Stomach problems                   |
| <input type="checkbox"/> Heart Problem            | <input type="checkbox"/> Thyroid problems                   |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Vision Problems                    |

Cancer    If yes for cancer, what type and any required treatment? \_\_\_\_\_

\_\_\_\_\_

Surgeries    If yes for surgeries, what type? \_\_\_\_\_

\_\_\_\_\_

Are there any other medical problems not listed above? If so, please list here: \_\_\_\_\_

\_\_\_\_\_

**CURRENT NON-PSYCHIATRIC MEDICATIONS:**

Name	Dosage	When Prescribed	Response
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drug Allergies and Reactions: \_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Please Circle: Parent/Guardian/Other \_\_\_\_\_)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Please circle: Adolescent/Child)