CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

3201 Hallmark Court
Saginaw, MI 48603
Phone: 989-790-5990
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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:

	Name	Location	When (month/year)?	For how long?
Psychiatrist:				
Therapist:				

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

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

CURRENT PSYCHIATRIC MEDICATIONS for your child/adolescent:

Name	Dosage	When Prescribed	Prescribed By	Response

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

Name	Highest Dosage	Duration	Response	Reason for Stopping

SUBSTANCE USE of your child/adolescent:

	Type	Average Usage	Current	Past	When Last Used
Caffeine			☐	☐	
Nicotine			☐	☐	
Alcohol			☐	☐	
Marijuana			☐	☐	

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

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
_____
_____
_____
_____
_____
_____
_____

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?

☐ Too Old	☐ Too much time together	☐ Drug/Alcohol Use
☐ Too Young	☐ Truant	☐ Violence
☐ Too Many	☐ Gang	☐ Sexual Promiscuity
☐ Too Few	☐ Fringe	☐ 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 1st 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:

☐ Allergies
☐ Anemia/ Low Iron
☐ Arthritis
☐ Asthma
☐ Bedwetting/Toilet Issues
☐ Back or Neck Pain
☐ Chronic Nosebleeds
☐ Diabetes
☐ Hearing Problem
☐ Heart Problem
☐ High Blood Pressure
☐ High Cholesterol
☐ IBS/Crohn's Disease/Celiac Disease
☐ Kidney Disease
☐ Liver disease
☐ Menstrual Problems
☐ Migraine Headaches
☐ Obesity
☐ Skin Conditions/Eczema/Dermatitis
☐ Stomach problems
☐ Thyroid problems
☐ 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 <u>NON-PSYCHIATRIC</u> MEDICATIONS:

Name Dosage When Prescribed Response

_____

_____

_____

_____

Drug Allergies and Reactions: _____

_____

_____

Signature:_____ **Date:** _____

(*Please Circle*: Parent/Guardian/Other_____)

Signature:_____ **Date:** _____

(*Please circle*: Adolescent/Child)