



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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 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:

- | | |
|---|---|
| <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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Allergies and Reactions: _____

Signature: _____ **Date:** _____

(Please Circle: Parent/Guardian/Other _____)

Signature: _____ **Date:** _____

(Please circle: Adolescent/Child)