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CHILD/ADOLESCENT INTAKE FORM

Today's date: _____

Patient Information:

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

Gender M/F Ethnicity (optional): _____

Name of Person completing this form: _____

Relationship to individual: _____ Years known: _____

Residence of child: (circle) Biological parents Adoptive parents Foster parents PCS Home

Other: _____

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 code)

Father's Address: _____
(street) (city) (state) (zip code)

Contact phone numbers:
Name/Relationship: _____ Number: _____

Who has legal/physical custody? _____ Type: _____
(please provide legal documentation)

Support Services:

Does this individual receive services from Health and Welfare? ☐ Yes ☐ No
Case Worker (name): _____ Phone: _____
Services Received: _____ Region: _____

Referral Information:

Who referred you to this clinic?

Name _____

Address _____

Phone _____

Presenting Problem:

What concerns you most about this individual?

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?

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? _____

_____

_____

Sleep Patterns:

Total hours of sleep per night: _____ Usual Schedule: _____ to _____

Does the individual take naps during the day? ☐ Yes ☐ No

If Yes, how many hours in a typical day? _____

Concerns:	Current Problem	Change within last 6 months
Difficulty falling asleep:	☐ Yes ☐ No	☐ Yes ☐ No
Frequent awakening:	☐ Yes ☐ No	☐ Yes ☐ No
Snoring:	☐ Yes ☐ No	☐ Yes ☐ No
Restlessness/Movements:	☐ Yes ☐ No	☐ Yes ☐ No
Early morning awakening:	☐ Yes ☐ No	☐ Yes ☐ No
Nightmares:	☐ Yes ☐ No	☐ Yes ☐ No
Not rested:	☐ Yes ☐ No	☐ Yes ☐ No

If yes to any of the concerns listed above, please describe: _____

_____

_____

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 this individual's current psychiatric medications. (You may refer to the list of medications on the next page)

Name *Dosage* *Duration* *Response*

Please list this individual's 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). *(You may refer to the list of medications on the next page).*

Name *Highest Dosage* *Duration* *Response* *Reason for Stopping*

Example: Dexedrine, 5 mg twice daily, 09/98-11/98, good, poor sleep

Drug and Alcohol History:

Substance	Date of Last Use	Problems Related to Use	Treatment Required
Benzodiazepines (Valium, Xanax, Ativan)		☐ Yes ☐ No	☐ Yes ☐ No
Caffeine		☐ Yes ☐ No	☐ Yes ☐ No
Marijuana		☐ Yes ☐ No	☐ Yes ☐ No
Cocaine		☐ Yes ☐ No	☐ Yes ☐ No
Designer Drugs (Club Drugs: G, X)		☐ Yes ☐ No	☐ Yes ☐ No
Hallucinogens (LSD, Mushrooms)		☐ Yes ☐ No	☐ Yes ☐ No
Inhalants (Gasoline, Glue, Aerosol)		☐ Yes ☐ No	☐ Yes ☐ No
Methamphetamines (Speed, Ice, Ritalin)		☐ Yes ☐ No	☐ Yes ☐ No
Opiates/Methadone (Vicodin, OxyContin, Heroin)		☐ Yes ☐ No	☐ Yes ☐ No
OTC – *Over the counter* (Benadryl, Nyquil, Dramamine)		☐ Yes ☐ No	☐ Yes ☐ No

Tobacco ☐ none Amount per day:

Is there anything else we should know about any drug history?

Adderall® (dextroamphetamine + amphetamine)

Abilify® (aripiprazole)

Adipex-P® (phentermine)

Ambien® (zolpidem)

amitriptyline (Elavil®)

Amoxapine

Antabuse® (disulfiram)

Anafranil® (clomipramine)

Aricept® (donepezil)

Ativan® (lorazepam)

Aventyl® (nortriptyline)

Benadryl® (diphenhydramine)

Buspar® (buspirone)

Carbatrol® (carbamazepine)

Catapres® (clonidine)

Celexa® (citalopram)

Chloral hydrate

Clozaril® (clozapine)

Cogentin® (benztropine)

Concerta® (methylphenidate)

Cymbalta® (duloxetine)

Cylert® (pemoline)

Dalmane® (flurazepam)

Depakote®/Depakene® (valproic acid/ valproate)

Dexedrine® (dextroamphetamine)

Didrex® (benzphetamine)

Dilantin® (phenytoin)

Dolophine®/Methadose® (methadone)

Effexor XR® (venlafaxine)

Elavil® (amitriptyline)

Ephedra®

Eskalith® (lithium)

Evening primrose oil

Focalin® (dexmethylphenidate)

Gabitril® (tiagabine)

Geodon® (ziprasidone)

Ginkgobiloba

®®Tofranil®®®®®escitalopram®®®®®

Marplan® (isocarboxazid)

Meridia® (sibutramine)

Metadate® (methylphenidate)

Methylin® (methylphenidate)

Moban® (molindone)

Mysoline® (primidone)

Nardil® (phenelzine)

Navane® (thiothixene)

Neurontin® (gabapentin)

Norpramin® (desipramine)

Nortriptyline (Pamelor®)

Omega fatty acids

Orap® (pimozide)

Pamelor® (nortriptyline)

Parnate® (tranylcypromine)

Paxil® (paroxetine)

Periactin® (cyproheptadine)

Prolixin® (fluphenazine)

Propranolol (Inderal®)ProSom® (estazolam)

Protriptyline (Vivactil®)

Provigil® (modafinil)

Prozac® (fluoxetine)

Remeron® (mirtazapine)

Restoril® (temazepam)

ReVia® (naltrexone)

Risperdal® (risperidone)

Ritalin® (methylphenidate)

SAM-e

Saint john's wort

Sarafem® (fluoxetine)

Serax® (oxazepam)

Seroquel® (quetiapine)

Serzone® (nefazodone)

Sinequan® (doxepin)

Sonata® (zaleplon)

Stelazine® (trifluoperazine)

Strattera® (atomoxetine)

Subutex® (buprenorphine)

Suboxone® (buprenorphine + naloxone)

Symbiax® (olanzapine + fluoxetine)

Tegretol® (carbamazepine)

Tenex® (guanfacine)

Tenuate® (diethylpropion)

Thorazine® (chlorpromazine)

Tofranil® (imipramine)

Topamax® (topiramate)

Tranxene® (clorazepate)

Trazodone (Desyrel®)

Trilafon® (perphenazine)

Trileptal® (oxcarbazepine)

Valerian

Valium® (diazepam)

Vistaril® (hydroxyzine)

Wellbutrin® (bupropion)

Xanax® (alprazolam)

Zarontin® (ethosuximide)

Zoloft® (sertraline)

Zonegran® (zonisamide)

Zyprexa® (olanzapine)

Zydis® (olanzapine)

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/Drug Problems _____
_____ Learning Disabilities _____
_____ Autism/Asperger/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:

Did your child achieve the following milestones early (E), average (A), or late (L) compared with other his/her age (please explain if late):

_____ 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? ☐ Yes ☐ No If yes, explain: _____

_____

_____

_____

Pregnancy and Birth History:

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

Was this the biological mother's first pregnancy? ☐ Yes ☐ No

If no, how many times was she pregnant before this pregnancy? _____

Did the biological mother experience any miscarriages before or after this pregnancy? ☐ Yes ☐ No

If yes, how many? _____ During what trimester? _____

When was prenatal care first received (in weeks): _____

How much weight did the biological mother gain during this pregnancy?: _____

Baby's birth weight and length: _____

Length of pregnancy (in weeks): _____

Did the mother have any ultrasounds or amniocentesis? ☐ Yes ☐ No If yes, please describe the reason for these and the results: _____

_____

_____

Please indicate whether any of the following events/problems occurred during this pregnancy. Please include the trimester in which the event occurred, as well as any other important details.

	Yes / No	# of months into pregnancy	Additional details
Infections/Colds	☐ Yes ☐ No		
Fevers	☐ Yes ☐ No		
Hospitalizations	☐ Yes ☐ No		
Vaginal bleeding, spotting	☐ Yes ☐ No		
Problems with diet	☐ Yes ☐ No		
Pregnancy induced Hypertension	☐ Yes ☐ No		
High blood pressure, excessive swelling	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No		
Rh or Blood Incompatibilities	☐ Yes ☐ No		
Trauma (emotional stress and/or physical injury)	☐ Yes ☐ No		

Did you take any medications (prescription and over the counter) during this pregnancy? (If yes, please complete the following table.)

Medication	Month(s) taken (1-9)	Dose	Reason for taking

Did you consume alcohol during this pregnancy? ☐ Yes ☐ No
If yes, how much and how often? _____

Did you smoke or use tobacco products during this pregnancy? ☐ Yes ☐ No
If yes, please describe how much and how often? _____

Did you use any drugs during this pregnancy? ☐ Yes ☐ No
If yes, please name drug(s), how much and frequency of use: _____
_____
_____
_____

Labor Information:
Type of delivery (c-section, vaginal): _____
Were forceps used? _____
Were there any problems with the baby's health right before or immediately after delivery? ☐ Yes ☐ No
If yes, please describe: _____
Were the mother and/or baby separated after birth for more than 24 hours at a time? ☐ Yes ☐ No
If yes, please explain: _____

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: _____

Allergies (drug, food, seasonal, environmental etc.)? ☐ Yes ☐ No If yes, please name and describe your child's reaction: _____

Has your child ever experienced a head injury, loss of consciousness, or seizure? ☐ Yes ☐ No
If yes, please describe: _____

Does your child have any chronic medical problems? ☐ Yes ☐ No If yes, please describe: _____

Does your child have a history of any serious injuries or medical hospitalizations? ☐ Yes ☐ No
If yes, please describe: _____

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? ☐ Yes ☐ No
If yes, please describe: _____

Do you have any concerns related to your child's balance or ability to walk? _____
Has your child had a significant unintentional or unexpected fall in the past year? _____
(consider referral to STARS if yes)

In the past year, has your child lost or gained weight without meaning to?
How much and in what time frame? _____
How many meals a day does your child eat? _____

Have you recently worried that your child may have problems with:

☐ Heart ☐ Constipation/Diarrhea Age of first menses _____
☐ Lungs ☐ Frequent infections Regular or Irregular cycle _____
☐ Kidneys/Bladder ☐ Endocrine (i.e., diabetes; thyroid dysregulation; excessive hair growth)
☐ Neurological ☐ Immunizations up to date

Has your child ever had an EEG, MRI, CT SCAN, etc? ☐ Yes ☐ No _____
If yes, why was it done and were the results normal? _____
If yes, where were the tests performed and who ordered them? _____

Social History:

Is your child your biological child? ☐ Yes ☐ No
If no, at what age was he/she adopted? _____

Is there any contact with their biological parent(s)? _____
Where was your child born and raised? _____

Has your child moved a number or times? ☐ Yes ☐ No _____

If yes, please list their age at time of move and location: _____

Parents: (Including Step-Mother and Step-Father, if applicable)

Name	*Education*	*Occupation*	*Hrs/Wk*	*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? ☐ Yes ☐ No

If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical	Emotional	Neglect
Accidents	Disasters	Sexual
Witnessing violence	Other	

Are you struggling with your marital relationship or parenting? ☐ Yes ☐ No

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 Childrens Mental Health _____
☐ Yes ☐ No Probation/Juvenile Probation/Detention _____
☐ Yes ☐ No Boys and Girls Club _____
☐ Yes ☐ No Youth Services _____
☐ 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? ☐ Yes ☐ No If yes, please describe: ___

Has your child received IQ or Academic testing? ☐ Yes ☐ No If yes, what were the results? _____

Does or has your child participated 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: _____
☐ Yes ☐ No Virtual Academy, 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: _____

What are your child's favorite activities? _____

How does your child learn best?
Verbal explanations_____
Written informational handouts_____
Other _____

Does your child have any significant problems that might affect learning? (Such as, trouble seeing or hearing, difficulty in understanding, speaking a different language, other)

_____

_____

Peers:

Does your child have quality relationships with other children? ☐ Yes ☐ No If no, please explain: _____

_____

_____

Culture:

Do you have a religious preference in the household? ☐ Yes ☐ No If yes, what is that preference? _____

_____

Has your child experienced any problems related to race, religion, or culture? ☐ Yes ☐ No If yes, please explain: _____

TEEN/YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent's friendships? ☐ Yes ☐ No
(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? ☐ Yes ☐ No If yes, what changes, if any are concerning to you? _____

Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? ☐ Yes ☐ No If yes, please describe: _____

Are you concerned about your child's sexual activities? ☐ Yes ☐ No _____
Is your adolescent sexually active? ☐ Yes ☐ No _____
Does your adolescent have a job? ☐ Yes ☐ No _____
Has your adolescent's behavior ever resulted in police, detention, or court involvement? ☐ Yes ☐ No
If yes, please explain: _____

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

Patient Name: _____ DOB _____

Mental Status Exam:

Clinical Interview Notes:

Three wishes

Wants to be when grow up

Happiest time

Saddest time

Scariest time

INITIAL FORMULATION:

INITIAL DIAGNOSES:

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

INITIAL TREATMENT PLAN:

1. MEDICATIONS:
2. PSYCHOTHERAPY:
3. MEDICAL:
4. ACADEMIC:
5. FOLLOW UP:
6. CRISIS (IF APPLICABLE):