Child Intake Form

Name: _____ Date: _____

What are the goals for your child's treatment? What changes would you like to see?
Is your child bothered by problems with sleep? ( ) Yes ( ) No Please describe:
Is your child bothered by hearing or seeing things, or by voices? ( ) Yes ( ) No Please describe:
Does your child have difficulty with focusing on tasks or finishing things? ( ) Yes ( ) No Please describe:

Psychiatric History:		
Is your child currently receiving any type of psychotherapy or counseling?	( ) Yes ( ) No	
If yes, by whom?	Phone:	
Does your child have a history of mental health problems or hospitalizations? If so please complete the following:	( ) Yes ( ) No	
Diagnosis	**Dates Treated**	**By Whom**

Most parents have thoughts or opinions about the use of psychiatric medications used to treat children. Please explain your views on mental health medications for your child:

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Medications taken previously (if any):			☐ My child has never taken medication		
	Prozac (fluoxetine)		Lamictal (lamotrigine)		Buspar (buspirone)
	Zoloft (sertaline)		Topomax		Adderall (amphetamine)
	Luvox (fluvoxamine)		Seroquel (quetiapine)		Concerta (methylphenidate)
	Paxil (paroxetine)		Risperdal (resperidone)		Ritalin (methylphenidate)
	Celexa (citalopram)		Zyprexa (olanzapine)		Strattera (atomoxetine)
	Lexapro (escitalopram)		Geodon (ziprasidone)		Vyvanse (lisdexamphetamine)
	Effexor (venlafexine)		Abilify (aripiprazole)		Focalin (dexmethylphenidate)
	Pristiq (desvenlafexine)		Tenex (guanfacine)		Daytrana patch (methylphenidate patch)
	Cymbalta (duloxetine)		Vistaril (hydroxyzine)		Intuniv (guanfacine ER)
	Wellbutrin (bupropion)		Xanax (alprazolam)		Clonidine
	Desyrel (trazodone)		Ativan (lorazepam)		Neurontin (gabepentin)
	Remeron (mirtazapine)		Restoril (temazepam)		Emsam (selegiline patch)
	Tegretol (carbamazepine)		Klonopin (clonazepam)		Other medications:
	Lithium		Valium (diazepam)		
	Depakote (valproate)		Ambien (zolpidem)		

Medical Information

ALLERGIES:

Other current prescription medications:

Medication	Dosage	Frequency	Side Effects

Current over the counter medications, herbal remedies, and nutritional supplements:

Current medical problems:

Past medical problems, hospitalizations, and surgeries:

Do you have any other concerns about your child's health that you'd like to discuss with me during our appointment?	( ) Yes ( ) No
Primary care provider:	
Date and place of last physical exam:	

Has you child ever had an EKG (heart)? ( ) No ( ) Yes/Date: _____ If yes, please describe:

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Medical Information (continued)
An MRI/PET/CT brain scan? ( ) No ( ) Yes/Date: _____ If yes, please describe:
An EEG (monitor for seizures)? ( ) No ( ) Yes/Date: _____ If yes, please describe:

Check if your child has a history of:					
	Anemia		Anxiety		Asthma
	Attention problems		Bipolar		Cancer
	Depression		Dental problems		Diabetes
	Digestive problems		Ear infections		Feeding problems
	Heart problems		Head trauma		Panic attacks
	Psychosis		Seizures		Strep infections
	Speech problems		Stomach problems		Other:

Family History:
If your child has biological relatives who have experienced the above or other health problems, please describe:

Please list all biological relatives who have been diagnosed with the following conditions:			
Depression		Anxiety	
Anger		Violence	
ADHD/ADD		Alcohol abuse	
Eating disorder		Drug abuse	
Bipolar (manic depressive)		Schizophrenia	
To your knowledge, has any family member attempted suicide?	( ) No ( ) Yes	If yes, whom?	
Has any family member been treated with a psychiatric medication? ( ) No ( ) Yes If yes, what medications, and how effective were they?			

Substance Use:	
Has your child ever been treated for alcohol or drug use or abuse?	( ) No ( ) Yes | If yes, for which substances?
If yes, where were they treated and when?	
To your knowledge, has your child ever tried alcohol or other drugs?	( ) No ( ) Yes

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Legal History:
Has your child ever been arrested? ( ) No ( ) Yes | If yes, please explain:
Does your child have any pending legal problems? ( ) No ( ) Yes | If yes, please explain:

Developmental History:	
Was your child adopted? ( ) No ( ) Yes | If yes, at what age?	
When your child was born were there any medical concerns during labor, delivery or immediately after his/her birth? If yes please describe:	( ) No ( ) Yes ( ) Not sure
Developmental milestones (sitting up, walking, talking, toilet training, etc.) were: ( ) On time ( ) Delayed ( ) Earlier than other children ( ) Not sure	
How many brothers or sisters? How old are they?	
Mothers occupation:	Fathers occupation:
Has your child experienced parental divorce? ( ) No ( ) Yes | If yes, how old was your child?	
If so, with whom does your child live?	
Describe your child's relationship with you:	
Describe your child's relationship with their other parent(s):	
What, if any, are your child's responsibilities at home?	

Vaccination History
Trauma History ( ) No ( ) Yes | If yes, please briefly describe circumstances: To your knowledge, was your child ever physically, verbally, or sexually abused?

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Spirituality	
Does your family belong to a particular religion or spiritual group? If yes, what is the level of your family's involvement?	( ) No ( ) Yes
If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is particularly important to you? Please explain:	( ) No ( ) Yes

Educational History:				
What school does your child attend?				
How are his/her grades?				
Does your child have any identified learning disabilities?				
If your child has had any specialized academic testing, please describe:				
How does your child do socially at school?				
What are your child's best subjects?				
Worst subjects?				
What do your child's teachers say about him/her?				

Recreation:				
What kind(s) of exercise does your child get?				
In what after school activities does your child participate?				
Does your child play video games?	( ) No ( ) Yes | If yes, how many hours per day?		Per week?	
Does your child watch television?	( ) No ( ) Yes | If yes, how many hours per day?		Per week?	
Does your child have television or computer in their bedroom?	( ) No ( ) Yes			
Does your child have their own cell phone?	( ) No ( ) Yes			
How often does your child visit with his or her friends?				
What do you think about your child's group of friends?				
What are your child's personal strengths?				

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Other Concerns
What are your child's personal strengths?
Please describe any concerns abut your cost of treatment (copay, medication costs, etc.)
Your child's comfort is very important, and some material is better discussed with them not present. Is there anything in the above information that you do not want your child to know?

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TRAUMA HISTORY

Prior to your 18th birthday:

Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

No___If Yes, enter 1 __

Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

No___If Yes, enter 1 __

Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

No___If Yes, enter 1 __

Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

No___If Yes, enter 1 __

Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No___If Yes, enter 1 __

Were your parents ever separated or divorced?

No___If Yes, enter 1 __

Was your mother or stepmother:

Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No___If Yes, enter 1 __

Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

No___If Yes, enter 1 __

Was a household member depressed or mentally ill, or did a household member attempt suicide?

No___If Yes, enter 1 __

Did a household member go to prison?

No___If Yes, enter 1 __