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CHILD/ ADOLESCENT INTAKE FORM

Please complete on behalf of your child

Name of patient:_____ Date of birth:_____

Name of person completing this form:_____

Your relation to the child: _____

Phone: _____ Email: _____

ACADEMIC INFORMATION:

Name of child's school: _____
Grade/year: _____
Program: _____
Typical grades: _____

THE REASONS FOR YOUR CHILD'S VISIT:

_____
_____

How intense is your child's emotional distress? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)
Please describe:

_____

Overall, how much do the problems affect your child's ability to perform school, get along with others, and perform daily tasks such as chores? (Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating) Please describe:

_____

When did these problems start? What was going on in your child's life at that time?

_____

PSYCHIATRIC AND MEDICAL HISTORY

Please list any psychiatric or "mental" problems your child has been diagnosed with:

_____

_____

Please list any medical or "physical" problems that your child has been diagnosed with:

_____

_____

Please list any medications your child currently takes, and what they are taken for:

_____

_____

Please list any allergies to medication and reaction seen with drug:

_____

_____

MENTAL HEALTH TREATMENT HISTORY

Has your child ever been hospitalized for psychological or psychiatric reasons? No Yes
If yes, please describe when and where, and for which reasons.

_____

_____

Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

_____

_____

Has he/she ever been treated for any of the following (check all that apply):

___Depression
___ADHD
___Bipolar (Manic / Depressive) Disorder
___ Anxiety
___OCD
___Schizophrenia
___ Panic Attacks
___PTSD
___Alcohol Problems (including AA)
___Anorexia/ Bulimia
___Binge-eating
___Drug Problems
___ECT treatment

EMOTIONAL/BEHAVIORAL/CHEMICAL ISSUES

Has your child recently or currently experienced the following?

CONCERN	YES	NO	CONCERN	YES	NO
Recent Suicidal thoughts			Difficulty sleeping		
Suicide plans			Depression		
Suicide attempts			Loneliness, or hopelessness		
Self-inflicted injury behaviors			Crying often		
A tendency to be shy or sensitive			Frightening dreams or thoughts		
A strong dislike of criticism			Often annoyed by little things		
A frequent loss of temper			Difficulty completing tasks		
Difficulty expressing feelings			Violent or destructive behavior		
Nervousness, anxiety, or worry			Difficulty remembering		
Difficulty relaxing			Difficulty concentrating		
Difficulty making decisions			Mental Confusion		
Difficulty making friends			Difficulty with eating		

Please check any symptoms your child may be experiencing:

☐ Depression (sad, irritable, hopeless, poor sleep, crying, social withdrawal, lack of interest)

☐ Mood swings (energetic, little sleep, pleasure seeking, racing thoughts, extremely talkative, inappropriate sexual behaviors, grandiose)

☐ Anxiety (worry, restless, scared, poor sleep, obsessive thoughts and/or compulsive behavior)

☐ Behavioral problems (fights, anger, arguing, truancy, destruction of property, fire setting)

☐ Attention/Hyperactivity problem (difficulty with attention, hyperactive, impulsive, distractibility, not completing tasks)

☐ Abnormal Eating Behaviors (too much, too little, fear of weight gain, distorted body image, over exercising)

☐ Never tired

☐ Remembering Past Traumas (frequent nightmares, intrusive and/or recurring memories)

☐ Social/language impairment (limited vocabulary, mispronouncing words, under development of language ability for their age)

☐ Psychosis (hearing voices, seeing things, paranoia, delusions)

☐ Dissociation (feeling outside their body or thinking things are not real)

☐ Harming themselves intentionally/harming others
☐ Attempted suicide

CURRENT HABITS

Please describe your child's current habits in each of the following areas:

Smoking: _____
Drinking: _____
Drug use:_____
TV use: _____
Internet use: _____
Video game use:_____
Caffeine intake: _____
Exercise:_____
Eating: _____
Sleeping:_____
Fun and relaxation: _____
Chores and responsibilities:_____

Please tell us about your child's interests (sports, hobbies, talents, etc.)

_____

Does your child agree that the problem that she or he is seeking help for is problematic?

_____

Is there anything else that you would like to mention?

_____

Please sign and date:

Name of parent/guardian:_____Signature:_____