

Child/Teen Intake Form

Child's Name:		DOB:		Age:	
Biological Father:	Biological Mother:	No. of siblings:	Which no. is the child?		
Religion:	Race:	School:	Grade:		
Address:	City/ST:	Zip:	County:		
With whom is the child currently living:					
Home phone no.:		Parent's work no.:		Other no.:	
Referral Source:		Phone:		Fax:	

MAIN PURPOSE OF THE CONSULTATION (Please give a brief summary of the main problems/symptoms):

How long have the above symptoms occurred? Give date:

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

Date:	Type of Treatment:	Medications:	Currently taking?	Effective?
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

PRIOR DIAGNOSES:

MEDICAL HISTORY

Past/current medical conditions:

Currently being treated? Y N

Medications/vitamins/herbs:

Hospitalizations:

Date: Cause:

Date: cause:

NEUROPSYCHIATRIC HISTORY

Any history of head trauma, concussion, strokes or significant accidents? (describe):

Date:	Type of Accident/Diagnosis:	Hospitalization/Treatment?	Rehabilitation? Where?
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

History of seizures or seizure like activity? Y N Date seizures began:

Prior abnormal lab tests, X-rays, EEG, MRI, etc: Y N Date tests conducted:

Please bring pertinent medical records; lab results, MRI report, psychological testing, etc.

DEVELOPMENTAL HISTORY

Months gestation?	Complications? <input type="checkbox"/> Y <input type="checkbox"/> N List: _____	Hours mom in labor:
Vaginal or Cesarean birth (circle one)	Estimated birth weight:	
Milestones (walk, talk, etc.) reached on time? <input type="checkbox"/> Y <input type="checkbox"/> N	List if no: _____	

FAMILY HISTORY

Please indicate the presence of any condition listed below for both maternal and paternal relationships.

Father's side		Mother's side	
Schizophrenia/psychosis	<input type="checkbox"/> Y <input type="checkbox"/> N	Schizophrenia/psychosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Anxiety Disorder/OCD	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety Disorder/OCD	<input type="checkbox"/> Y <input type="checkbox"/> N
Bipolar Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Bipolar Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
Personality Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Personality Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
Substance Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N	Substance Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N
Mental Retardation/LD	<input type="checkbox"/> Y <input type="checkbox"/> N	Mental Retardation/LD	<input type="checkbox"/> Y <input type="checkbox"/> N
Autism/Asperger's/PDD	<input type="checkbox"/> Y <input type="checkbox"/> N	Autism/Asperger's/PDD	<input type="checkbox"/> Y <input type="checkbox"/> N
Eating Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	Eating Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N
History of abuse/neglect	<input type="checkbox"/> Y <input type="checkbox"/> N	History of abuse/neglect	<input type="checkbox"/> Y <input type="checkbox"/> N
Genetic Medical Condition	<input type="checkbox"/> Y <input type="checkbox"/> N	Genetic Medical Condition	<input type="checkbox"/> Y <input type="checkbox"/> N
Other _____		Other _____	
Dad deceased? <input type="checkbox"/> Y <input type="checkbox"/> N	Cause? _____	Mom deceased? <input type="checkbox"/> Y <input type="checkbox"/> N	Cause? _____

PSYCHOSOCIAL HISTORY

Blended family (stepmom/dad, etc.)? <input type="checkbox"/> Y <input type="checkbox"/> N	Number of stepchildren?	
History of substance abuse? <input type="checkbox"/> Y <input type="checkbox"/> N	Age abuse began? _____	Years sober or longest attempt at sobriety?
Drug of choice:	Treatment received? <input type="checkbox"/> Y <input type="checkbox"/> N	Inpatient or Outpatient (circle applicable)
Problems with sleeping? <input type="checkbox"/> Y <input type="checkbox"/> N	Explain:	
Problems with eating? <input type="checkbox"/> Y <input type="checkbox"/> N	Explain:	
Number of detentions:	Charges: _____	Years served:
Other contact with the legal system: <input type="checkbox"/> Y <input type="checkbox"/> N	Explain:	
History of physical/sexual abuse?	Age abuse began: _____	Treatment received? <input type="checkbox"/> Y <input type="checkbox"/> N
History of mental abuse/neglect?	Age abuse began: _____	Treatment received? <input type="checkbox"/> Y <input type="checkbox"/> N
Personal strengths:	Personal weaknesses:	
Current life stresses:		
Explain coping strategies:		

EDUCATIONAL HISTORY

Last grade completed:	Current school:	No. of schools attended:	
Special education: <input type="checkbox"/> Y <input type="checkbox"/> N	Gifted classes? <input type="checkbox"/> Y <input type="checkbox"/> N	Behavior problems? <input type="checkbox"/> Y <input type="checkbox"/> N	Retained? <input type="checkbox"/> Y <input type="checkbox"/> N
Other problems in school? <input type="checkbox"/> Y <input type="checkbox"/> N	Explain:		
Average grades or g.p.a.:	Academic/achievement testing performed in school? <input type="checkbox"/> Y <input type="checkbox"/> N		
Social problems in school? <input type="checkbox"/> Y <input type="checkbox"/> N	Belongs to a group? <input type="checkbox"/> Y <input type="checkbox"/> N	Best friend? <input type="checkbox"/> Y <input type="checkbox"/> N	Age:
Test anxiety? <input type="checkbox"/> Y <input type="checkbox"/> N	Completes homework? <input type="checkbox"/> Y <input type="checkbox"/> N	Distractible? <input type="checkbox"/> Y <input type="checkbox"/> N	
Attitude towards school/teachers:	Favorite subject:		
Intramural activities:	Extramural activities:		