

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? <input type="checkbox"/> Y <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N		Date seizures began:	
Prior abnormal lab tests, X-rays, EEG, MRI, etc: <input type="checkbox"/> Y <input type="checkbox"/> N		Date tests conducted:	
N			
<i>Please bring pertinent medical records; lab results, MRI report, psychological testing, etc.</i>			
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.			
<u>Father's side</u>		<u>Mother's side</u>	
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:		

Patient Name: _____

Signature of Patient (over 13 years old): _____

Signed By Parent/Legal Guardian: _____

Today's Date: _____