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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Child Intake Form** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Legal Name: | | | | | | | | | Preferred Name: | | | | | | | | | | | | | DOB: | | | | | | Age: |
| SSN: | | | | | | Parent/Guardian: | | | | | | | | | | | | | | | | |  |  | | | | |
| Religion: | | | Sex: | | | Gender Identity: | | | | | | | | | Race: | | | | | | Marital Status: | | | | | | No. of children: | |
| Address: | | | | | | | | | | | | City, ST Zip: | | |  | | | | | | | | | | County: | | | |
| Emergency Contact/Relationship/Phone #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| With whom are you currently living: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Referral Source: | | | | | | | | | Phone: | | | | | | | | Email: | | | | | | | | | | | |
| **MAIN PURPOSE OF THE CONSULTATION** (Please give a brief summary of the main problems/symptoms): | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How long have the above symptoms occurred? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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? |
|  |  | | | | | | | | | |  | | | | Y N | | | | | | | | | | | | | Y N |
|  |  | | | | | | | | | |  | | | | Y N | | | | | | | | | | | | | Y N |
|  |  | | | | | | | | | |  | | | | Y N | | | | | | | | | | | | | Y N |
|  |  | | | | | | | | | |  | | | | Y N | | | | | | | | | | | | | Y 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? | | |
|  |  | | | | | | | | | | | | | Y N | | | | | | | | | | | | Y N | | |
|  |  | | | | | | | | | | | | | Y N | | | | | | | | | | | | Y N | | |
|  |  | | | | | | | | | | | | | Y N | | | | | | | | | | | | Y 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? Y N List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | Hours mom in labor: | | | | |
| Vaginal or Cesarean birth (circle one) | | | | | | | | Estimated birth weight: | | | | | | | | | | | | | | | | | | | | |
| Milestones (walk, talk, etc.) reached on time? Y N List if no:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FAMILY HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No. of siblings in your childhood family? | | | | | | | | | | | | | | Which number are you? | | | | | | | | | | | | | | |
| Father’s side | | | | | | | | | | | | | | Mother’s side | | | | | | | | | | | | | | |
| Schizophrenia/psychosis | | | | | Y N | | | | | | | | | Schizophrenia/psychosis | | | | | | | | | | | | Y N | | |
| Depression | | | | | Y N | | | | | | | | | Depression | | | | | | | | | | | | Y N | | |
| Anxiety Disorder/OCD | | | | | Y N | | | | | | | | | Anxiety Disorder/OCD | | | | | | | | | | | | Y N | | |
| Bipolar Disorder | | | | | Y N | | | | | | | | | Bipolar Disorder | | | | | | | | | | | | Y N | | |
| Personality Disorder | | | | | Y N | | | | | | | | | Personality Disorder | | | | | | | | | | | | Y N | | |
| Substance Abuse | | | | | Y N | | | | | | | | | Substance Abuse | | | | | | | | | | | | Y N | | |
| Mental Retardation/LD | | | | | Y N | | | | | | | | | Mental Retardation/LD | | | | | | | | | | | | Y N | | |
| Autism/Asperger’s/PDD | | | | | Y N | | | | | | | | | Autism/Asperger’s/PDD | | | | | | | | | | | | Y N | | |
| Eating Disorder | | | | | Y N | | | | | | | | | Eating Disorder | | | | | | | | | | | | Y N | | |
| History of abuse/neglect | | | | | Y N | | | | | | | | | History of abuse/neglect | | | | | | | | | | | | Y N | | |
| Genetic Medical Condition | | | | | Y N | | | | | | | | | Genetic Medical Condition | | | | | | | | | | | | Y N | | |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Dad deceased? Y N | | | | | Cause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | Mom deceased? Y N | | | | | | | | | | | | Cause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **PSYCHOSOCIAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number of marriages? | | | | | | | Number of biological children? | | | | | | | | | | | | Number of stepchildren? | | | | | | | | | |
| History of substance abuse? Y N | | | | | | | | | | Age abuse began? | | | | | | Years sober or longest attempt at sobriety? | | | | | | | | | | | | |
| Drug of choice: | | | | | | | | Treatment received? Y N | | | | | | | | | | | | | | Inpatient or Outpatient (circle applicable) | | | | | | |
| Problems with sleeping? Y N | | | | | | | | Explain: | | | | | | | | | | | | | | | | | | | | |
| Problems with eating? Y N | | | | | | | | Explain: | | | | | | | | | | | | | | | | | | | | |
| Number of incarcerations: | | | | | | | | Charges: | | | | | | | | | | | | Years served: | | | | | | | | |
| Other contact with the legal system: Y N | | | | | | | | | | | | | Explain: | | | | | | | | | | | | | | | |
| Currently employed? Y N | | | | | | | | Years on job: | | | | | | | | | | Longest time employed: | | | | | | | | | | |
| Military service? Y N | | | | | | | | Branch: | | | | | | | | | | | | Years of service: | | | | | | | | |
| History of physical/sexual abuse? | | | | | | | | Age abuse began: | | | | | | | | | | | | Treatment received? Y N | | | | | | | | |
| History of mental abuse/neglect? | | | | | | | | Age abuse began: | | | | | | | | | | | | Treatment received? Y N | | | | | | | | |
| Personal strengths: | | | | | | | | | | | | | | Personal weaknesses: | | | | | | | | | | | | | | |
| Current life stresses: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Explain coping strategies: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EDUCATIONAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last grade completed: | | | | | | Highest degree awarded: | | | | | | | | | | | Training/specialty: | | | | | | | | | | | |
| Special education: Y N | | | | | | Gifted classes? Y N | | | | | | | | Behavior problems? Y N | | | | | | | | | | | | Retained? Y N | | |
| Other problems in school? Y N | | | | | | | | Explain: | | | | | | | | | | | | | | | | | | | | |
| Average grades or g.p.a.: | | | | | | | | Academic/achievement testing performed in school? Y N | | | | | | | | | | | | | | | | | | | | |