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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 |