CHILD PATIENT INTAKE INFORMATION

Date_____

Name_____Nickname:_____

DOB_____Age_____Sex____Race/Ethnicity:_____

Language(s) spoken at home:_____

Person completing form:_____Relationship to Child:_____

Child's Address_____

City_____State_____Zip_____

Home Phone_____Other (e.g. Cell Phone):_____

Medical Doctor_____Phone_____

Referred by_____Phone_____

May we contact you by email? YES NO **Your Email Address:**_____

Caregiver Information (**Custodial or Non Custodial**) Please circle one

Name_____Age_____Sex_____Relationship to Child:_____

Address if other than above_____

Work Phone _____Other Phone_____

Please indicate if we may leave a message at home:_____work:_____other:_____

Employer_____Position_____

Caregiver Information (**Custodial or Non Custodial**) Please circle one

Name_____Age_____Sex____Relationship to Child:_____

Address if other than above_____

Work Phone _____Other Phone_____

Please indicate if we may leave a message at home:_____work:_____other:_____

Employer_____Position_____

In Case Of Emergency Notify:

Name_____Relation_____

Phone_____Other#_____

PATIENT INFORMATION

Briefly, please describe the concerns about your child and/or the reason you are seeking services (e.g, any behavioral, emotional, or learning concerns at home and/or school, difficulties with peer relationships, etc):

Family Information

Parents' Marital Status: __Married __Never married ___Separated ___Divorced __Widowed

If separated or divorced, how long?____

Contact with non-custodial parent or custody arrangement if any:_____

Any special circumstances in the family situation? _____

Please list all individuals living in the home:

Name	Age	Relationship	Occupation/School

PATIENT INFORMATION

School Information

Name of School:_____School District:_____Phone:_____
Main Teacher (or teacher who knows your child best):_____Current Grade:_____

Placement and Services (current or past)	**No**	**Yes**	**Describe (e.g. when, which subject failed or grade repeated)**
Early Intervention			
Repeated Grade			
Suspended			
Failed or is failing a grade or subject			
Received any special education services			
Other (Please explain)			

Please describe any current special education services (e.g. IEP, 504 Plan, resource room support):

_____
_____
_____
_____
_____

Previous Evaluations and Treatments (please bring copies of any reports)

Testing (such as educational, emotional, speech/language)

Date	Type of Testing	Where was the testing done? (e,g, School, Private Psychologist, etc)

Outpatient Mental Health Professionals Seen:

Professional's Name/Specialty (e.g. psychiatrist, psychologist, social worker, school counselor)	Start Date	End Date	Type of services received

PATIENT INFORMATION

Is there any history of physical or sexual abuse?

_____

_____

_____

_____

_____

Child Protective Services Report? _____

If your child has taken medication for attention, behavior, or emotional problems, please list:

Medication	Dosage (e.g. 20 mg 3x day)	Start	End	Prescribed By	Adverse Effects

Please List ANY **Drug or Food Allergies**_____

If your child takes any other medication or supplements for any other reason, please list:

_____

Psychiatric Hospitalization or Inpatient Drug Treatment

Place	Date Started	Date Stopped	Reason for admission

Has your child or family received services or case management through an agency (e.g. Child Protective Services, Department of Mental Health and Mental Retardation, etc.)?

Agency:_____ Service:_____

Agency:_____ Service:_____

PATIENT INFORMATION

Child's Developmental/Health History

Pregnancy and Delivery

Age of mother at birth: ____yrs

Medications taken during pregnancy: _____

Gestational diabetes? Yes No

Problems with blood pressure or toxemia? Yes

No

Infections (including herpes) _____

Smoking (if so, how many packs per day) _____

Alcohol _____

Drugs taken _____

Any problems during labor or delivery: _____

Duration of pregnancy: _____weeks

Type of labor: _____

Birth weight: _____

Any problems after birth: _____

Infancy/Toddler

Describe your child as an infant and toddler: _____

Problems with feeding	Y	N
Severe colic or excessive crying	Y	N
Irritable	Y	N
Overactive	Y	N
Easily over stimulated	Y	N
Withdrawn	Y	N
Didn't like to be held	Y	N
Difficult to soothe	Y	N

Developmental Milestones:

Indicate the age at which your child achieved the following:

Sit up _____

Walk without assistance _____

Speak in 2 word sentences _____

Dry at night _____

Toilet trained during the day _____

PATIENT INFORMATION

Medical History

List Any Major Illnesses	Date	Hospitalized?	Surgery?

Has your child ever had a head injury with loss of consciousness? If yes, please describe:

_____

Has your child ever had a seizure? If yes, please describe:

_____

Family History

Does anyone in the child' **biological** family have:	No	Yes	Relationship to child
Attention problems/ADHD			
Behavior problems in youth			
Learning Disability			
Seizures			
Mental Retardation			
Tics/Tourette's Syndrome			
Autistic spectrum disorder			
Thyroid Problems			
Heart Problems before age 50			
Depression			
Bipolar Disorder			
Anxiety or Panic Attacks			
Obsessive Compulsive Disorder			
Schizophrenia			
Alcohol Problems			
Drug Problems			
Trouble with the law			

Any other significant family medical or psychiatric history_____

_____

Significant psychiatric, behavioral or medical problems in step-, adoptive, or foster family:_____

_____

_____