Child/Adolescent Psychiatric Evaluation Intake Form

1. Patient Contact Information

Patient Name_____ Age _____ Date of Birth_____
Last First MI

Address_____

Best contact phone number: _____Email address: _____

Primary Care Physician _____Tel _____Fax_____

Pharmacy _____ Phone #_____

Parent's or Guardian's Name _____

Home phone: _____ Work phone: _____ Cellular phone: _____

Parent's are: ❒ single ❒ married ❒ separated ❒ divorced ❒ remarried ❒ widowed ❒ cohabitating

If divorced, what are the custody arrangements? _____ (Please bring copy of custody agreement for the chart)

Please give other parent's address and phone number.
Name

_____

Address:

_____

Home/Cellular phone number: _____ Work phone number: _____

Where was your child born and raised?

Has your child moved a number or times? Yes No
If yes, please list their age at time of move and location:

Parents: (Including Step-Mother and Step-Father, if applicable)

Name	*Education*	*Occupation*	*Hrs/Wk*	*Relationship with Child (quality)*

Please list the other children in the family and other household members who may also be living in your home:

Name	*Age*	*Lives at Home?*	*Relation to Child*	*Relationship with Child*

2. SCHOOL HISTORY

Current grade level: _____Current school:_____ Teacher's name: _____

School address: _____ Phone:_____ Fax: _____

Please summarize child's progress (e.g., academic, social), within each of these grade levels:

Preschool

Kindergarten

Grades 1-3

Grades 4-5

Grades 6-8

Grades 9-12

What are your child's academic strengths?

Academic weaknesses?

Has there been a change in your child's performance at school? Yes No If yes, please describe:

Has your child received IQ or Academic testing? Yes No If yes, what were the results?

Does or has your child participated in any of the following?
Yes No Resource (for which classes/how many hours?)
Yes No Accelerated or Honors programs, explain:
Yes No Individual Education Plan (IEP), explain:
Yes No Virtual Academy, explain:
Yes No School Study Team (SST)
Yes No Speech and language therapy
Yes No Learning disabilities class
Yes No Behavioral/emotional disorders class

Has your child had problems with any of the following?
Yes No Truancy, explain:
Yes No Fights, explain:
Yes No Absenteeism, explain:
Yes No Detention, explain:
Yes No Suspension, explain:
Yes No School refusal, explain:

Please bring copies of Psychological, Educational, Speech, Occupational Therapy Evaluations, if applicable

AREAS OF CONCERN (check all that apply):

Personal/Social Adjustment:
( ) Unduly sad
( ) Overly anxious
( ) Overly aggressive
( ) Temper tantrums
( ) Withdrawn or shy
( ) Disturbing habits or mannerisms
( ) Strange or bizarre behavior
( ) Problems in peer relationships
( ) Drug or alcohol problems

School Adjustment
( ) Academic problems
( ) Difficulty with peers
( ) Difficulty with authority
( ) Behavior problems
( ) Attendance problems or reluctance to go to school
( ) Learning disabilities
( ) Attentional problems
( ) Aches and pains related to school
( ) Other (please specify):

( ) Problems with the law
( ) Harms self or others (suicidal or homicidal)
( ) Other (please specify):

Family Adjustment
( ) Parent-child problem
( ) Marital conflict or co-parenting problems
( ) Sibling conflict
( ) Recent family changes
( ) Neighborhood difficulties
( ) Mother experiencing difficulties
( ) Father experiencing difficulties
( ) Sibling experiencing difficulties
( ) Drug or alcohol problems in family
( ) History of trauma or loss
( ) Domestic violence ( ) Abuse ( ) Other (please specify):

Physical/Developmental Factors
( ) Eating
( ) Sleeping
( ) Toileting
( ) Grooming
( ) Perceptual/visual functions
( ) Language or speech
( ) Motor coordination problems
( ) Other, (please specify):

Abuse History:
Has your child ever been the victim of abuse or neglect? Yes No
If yes, what was the nature of the abuse? (Please circle all that apply.)
Physical Emotional Neglect Accidents Disasters Sexual Witnessing violence Other:

Are you struggling with your marital relationship or parenting? Yes No
If yes, please describe:

Has your child ever been involved with the following and if yes, please explain:
Yes No Child Protective Services
Yes No Childrens Mental Health
Yes No Probation/Juvenile Probation/Detention
Yes No Boys and Girls Club
Yes No Youth Services
Yes No Head Start
Yes No Early Intervention Services (ages 0-3)

TEEN/YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent's friendships? Yes No
(Please circle all that apply.) Too old Too young Truant Gang Fringe Too much time together
Drug/alcohol use Violence Too many Too few Sexual Promiscuity Other

Has your adolescent had a recent change in friendships? Yes No If yes, what changes, if any are concerning to you?

Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? Yes No If yes, please describe:

Are you concerned about your child's sexual activities? Yes No
Is your adolescent sexually active? Yes No
Does your adolescent have a job? Yes No
Has your adolescent's behavior ever resulted in police, detention, or court involvement?
Yes No If yes, please explain:

Is there anything else you would like us to know about your child?

What are your child's favorite activities?

Is the child currently seeing a therapist? (Name/contact #)_____

Have you ever seen a psychiatrist/psychotherapist before? If yes, please list:_____

Previous history: Has he/she ever been treated for any of the following (check all that apply):

____ Depression	_____ADHD	____ Bipolar (Manic / Depressive) Disorder	
____ Anxiety	_____OCD	____ Schizophrenia	
____ Panic Attacks	_____PTSD	____ Alcohol Problems (including AA)	
____Anorexia/ Bulimia	_____Binge-eating	____ Drug Problems	_____ECT treatment

Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Has he/she attempted to harm/kill themselves? If so, please list the occurrences below: Never

Approximate date of attempt	How did you attempt (method)?

Please List *all* current medications below(include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc)

Name of Medication	Dosage(Mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing physician

Please review the following list of medications. If he/she has taken any of these medications please fill out the specific boxes related to that medication.

Brand Name	**Generic Name**	**√ if yes**	**How long did you take it?**	**What Dosage did you take? Mg/d**	**Did it help? √ if yes**	**How often In a day?** Write **1, 2** or **3** times a day	**Any Side effects**
Selective Serotonin Reuptake Inhibitors(SSRIs)							
Luvox	Fluvoxamine						
Paxil	Paroxetine						
Paxil CR	Paroxetine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Zoloft	Sertaline						
Prozac	Fluoxetine						
Serotonin-Norepinephrine Reuptake Inhibitors(SNRIs)							
Effexor	Venlafaxine						
EffexorXR	Venlafaxine						
Pristiq	desvenlafaxin						
Cymbalta	Duloxetine						
Other Antidepressants							
Desyrel	Trazadone						
Serzone	Nefazodine						
Wellbutrin XL / SR	Bupropion XL/ SR						
Remeron	Mirtazapine						
Serzone	nefazodone						
Tricyclic Antidepressants							
Adapin	Doxepin						
Anafranil	Clomipramine						
Asendin	Amoxapine						
Elavil	Amitriptyline						
Ludiomil	Maprotiline						
Norpramin	Desipramine						
Pamelor	Nortriptyline						
Sinequan	Doxepin						
Surmontil	Trimipramine						
Tofranil	Imipramine						
Vivactil	Protriptyline						
Other Psychotropics (Have you taken any of these?)							
Abilify	Buprenorphin	Dexedrine	Ambien	Klonopin	Emsam	Provigil	Thorazine
Risperidal	Campral	Adderall	Buspar	Ativan	Nardil	Depakote	Dalmane
Invega	Antabuse	Vyvanse	Restoril	Xanax	Parnate	Lithium	Orap
Geodon	Suboxone	Strattera	Sonata	hydroxyzine	Halcion	Lamictal	Navane
Zyprexa	Naltrexone	Concerta	Buspar	Valium	Niravam	Phentermine	Trilafon
Seroquel	Ambien CR	Dexedrine	Halcion	vistaril	Tranxene	Tegretol	Mobane
Symbyax	Valproic Acid	Focalin	Atarax	Methadone	Cylert	Topamax	Stelazine
Clozapine	Adderall XR	Ritalin	Librium	Synthoid		Mellaril	Haldol
Rozerem	Metadate	Daytrana	Lunesta	Meridia		Loxitane	Prolixin

Family History :Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate indicate paternal or maternal)

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression								
Anxiety								
Panic Attacks								
Post traumatic stress								
Bipolar/Manicdepression								
Schizophrenia								
Alcohol Problems								
Drug problems								
ADHD								
Suicide attempts								
Psychiatric hospital stay								

Allergies (drug, food, seasonal, environmental etc.)? Yes No If yes, please name and describe your child's reaction:

Has your child ever experienced a head injury, loss of consciousness, or seizure? Yes No
If yes, please describe:

Does your child have any chronic medical problems? Yes No If yes, please describe:

Does your child have a history of any serious injuries or medical hospitalizations? Yes No
If yes, please describe:

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? Yes No
If yes, please describe:

Have you recently worried that your child may have problems with:

Heart Constipation/Diarrhea Age of first menses
Lungs Frequent infections Regular or Irregular cycle
Kidneys/Bladder Endocrine (i.e., diabetes; thyroid dysregulation; excessive hair growth)
Neurological Immunizations up to date

Has your child ever had an EEG, MRI, CT SCAN, etc? Yes No
If yes, why was it done and were the results normal?
If yes, where were the tests performed and who ordered them?