Dr. Marc Schwartz, DO

The ARIZONA SCHWARTZ GROUP
Child, Adolescent, Adult Psychiatry

Fax 866-831-1158
Tel 480-899-4077
www.azSchwartzGroup.com

Child & Adolescent Intake Form

Referred By

Name	Phone
Address	☐ Pediatrician ☐ Primary Care Physician ☐ Psychologist ☐ Counselor ☐ Friend

Patient Information

Name	Gender ☐ Male ☐ Female	Date
Address	DOB	Age
	Email	
Mobile Phone	Home Phone	

Parental or Guardian Information

Mother	Age	Father	Age
Address		Address *(if different)*	
Occupation		Occupation	
Home Phone		Home Phone	
Mobile Phone		Mobile Phone	
Work Phone		Work Phone	

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Social Services Agency *(if applicable)*

Is agency the Legal Guardian? ☐ *Yes* ☐ *No*

Agency Name	Contact Person
Address	Phone
	Fax

School Information *(Complete only those fields that apply)*

Name		Grade	Phone
Address		IEP: ☐ Yes ☐ No *If yes, what is IEP for:*	
Principal	Phone	Teacher	Phone
Psychologist	Phone	If Special Education, what services? ☐ Resource Room ☐ Occupational Therapy ☐ Speech-Language ☐ Physical Therapy/Ed ☐ 1 to 1 Para ☐ Other	
Guidance Counselor	Phone		

Family members residing in the home

Name	DOB	Age	Gender	Relationship
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐ ☐	
			☐ ☐	

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Mental Health History

Hospitalizations ☐ *Yes* ☐ *No* If yes, how many? _____

Hospitals	Date	Reason

Psychotherapy – *(Current and Past)*

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Clinician Name: _____ Dates _____ to _____

Phone: Fax: Email:

Prescriber – Physician or Nurse Practitioner *(Current and Past)*

Clinician Name: _____Dates _____ to _____

Type: Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: Fax: Email:

Clinician Name: _____Dates _____ to _____

Type: Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: Fax: Email:

Clinician Name: _____Dates _____ to _____

Type: Psychiatrist or Family Physician or Pediatrician or Nurse Practitioner

Phone: Fax: Email:

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Psychiatric Medication History

Current Psychiatric Medications and/or Supplements ☐ *Yes* ☐ *No*

Medication/Supplement	Dose	Start Date	Side Effects

Previous Psychiatric Medications and/or Supplements ☐ *Yes* ☐ *None*

Medication/Supplement	Dose	Start Date	Stop Date	Reason for stopping

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Medical History

Primary Care Doctor or Pediatrician

Name	Phone
Address	Fax

Medical or Surgical History

Medical Diagnosis or Surgery	Date Diagnosed	Treating Physician Name	Phone

Current Medications *(other than psychiatric)*

Medication	Dose	Start Date	Treating Diagnosis	Side Effects

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Allergies ☐ *None* ☐ *Yes (see below)*

Medication Allergies

Name	Reaction

Food Allergies

Name	Reaction

Food Sensitivities

Name	Reaction or Symptom

Other Allergies

Name	Reaction

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Family History of Mental Health Disorders *(Leave blank if not applicable)*

Diagnosis	Relationship to Patient	Treated or Untreated
Alcohol Abuse/Dependence		
Anger Problems		
Anxiety *(Generalized or Panic Disorder)*		
Attention Deficit Hyperactivity		
Autism		
Behavior/Conduct Problems		
Bipolar Disorder		
Depression		
Eating Disorders		
Gambling Problems		
Learning Disorders		
Intellectual Disability		
Obsessive Compulsive (OCD)		
Schizophrenia		
Suicide - Attempts		
Suicide - Completed		
Substance Abuse		
Tic Disorder		
Other		

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Developmental History

Birth History

Duration of Pregnancy (weeks) _____

Complications during Pregnancy ☐ No ☐ Yes, explain _____

Labor

Duration _____

Complications ☐ No ☐ Yes, explain _____

Delivery ☐ Vaginal ☐ C-Section

Complications, if any _____

Newborn Period ☐ Normal

☐ Problems or treatment needed (Oxygen, Incubator, Infection, Jaundice requiring treatment, Breathing difficulties, or other) _____

_____

Developmental Milestones

First Year - Temperament

☐ Yes ☐ No Easy Baby

☐ Yes ☐ No Slow to warm up _____

☐ Yes ☐ No Difficult baby _____

☐ Yes ☐ No Colic _____

Eating habits ☐ Normal ☐ Abnormal _____

Sleep habits ☐ Normal ☐ Abnormal _____

Milestones

Age at first words _____

Age speaking sentences _____

Age toilet trained:

Bladder _____

Bowel _____

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Social History

Peer Relationships ☐ Satisfactory ☐ Unsatisfactory *Explain*:

Reason for seeking treatment *(In Brief)*

Thank you for your time in completing this form. All of the information will help Dr. Schwartz provide a thorough and comprehensive assessment. Any additional information not covered in this form that you think is helpful and important information, please feel free to detail it below.

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Additional Information *(If applicable)*