NEW DIMENSION GROUP
Child Psychiatric Intake Form

All information on this form is strictly confidential.
Please complete the following form to help us understand your child. This will decrease the time needed to make an accurate evaluation of your child's needs. Please bring it to the first visit. Thank you!

Child's Name_____ Age _____ Date of Birth _____ Gender: Male or Female
Form Completed By: _____ How are you related to the child? _____
Whose idea was it to bring child to clinic? _____

What are your current concerns regarding your child and what problem(s) you are seeking help for?
1._____
2._____
3._____

At what age was the problem first noted? _____

Why do you think your child is having problems?_____

_____

Describe how child's problems affect you, other family members, others:_____
_____
_____
_____

What would you or referring person like to see done for your child? _____
_____
_____
_____

What, if anything, happened recently to make the problem(s) worse? _____
_____

Please review the following list and circle what you feel fit your child.

Sad/depressed	Seems angry	Sets fires	Looks "high" often
Cries frequently	Ignores rules	Steals	Separation problems
Worries a lot	Defies authority	Lies a lot	Imaginary friends
Suicidal Thoughts	Temper tantrums	Too serious	Family Problems
Sleeping Problems	Not completing schoolwork	Clowns a lot	School Problems
Lacks guilt/remorse	Acts before thinking	Acts spoiled	Motor/Vocal Tics
Difficulty making friends	Short attention-span	In own world	Bullying/Teasing
Difficulty keeping friends	Unable to sit still	Afraid/fearful	Aggressive
Little interest in friends	Overactive	Accident-prone	Fights a lot
Little interest in activities	Underactive	Seems insecure	Food Issues
Disrespectful	Self-Injurious Behavior	Mentally slow	
Argues	Hurts animals	Interested in sex	

Has he/she ever had treatment for this problem? _____

If so, Where? _____ When? _____

Yes	No	
____	____	Has your child ever been a patient of a psychiatrist? If yes, what was his/her diagnosis and how long was he/she treated? _____
____	____	Has your child ever been in talk therapy, play therapy or family therapy? If yes, with whom, when and for how long? _____
____	____	Has your child ever attempted suicide?
____	____	Has your child ever been hospitalized for any psychiatric reason? If yes, name the hospital(s), the date(s), and for what reason?

Date	Hospital Name	Reason for admission

Yes **No**

____ ____ Has your child ever taken any psychiatric medication? If yes, which ones? (see examples below)

Medication Taken and Dosage	Response/Side-Effects and Reason Discontinued

Some examples of PSYCHIATRIC MEDICATIONS are:

Antidepressants				
Celexa (citalopram)	*Prozac (fluoxetine)*	*Zoloft (sertraline)*	*Paxil (paroxetine)*	*Lexapro (escitalopram)*
Luvox (fluvoxamine)	*Effexor (venlafaxine)*	*Cymbalta (duloxetine)*	*Wellbutrin (bupropion)*	*Remeron (mirtazapine)*
Pristiq (duloxetine)	*Elavil (amitriptyline)*	*Anafranil (clomipramine)*	*Pamelor (nortrptyline)*	*Tofranil (imipramine)*
Mood Stabilizers				
Depakote (valproate)	*Lamictal (lamotrigine)*	*Tegretol (carbamazepine)*	*Topamax (topiramate)*	*Lithium*
Antipsychotics/Mood Stabilizers				
Seroquel (quetiapine)	*Zyprexa (olanzepine)*	*Geodon (ziprasidone)*	*Abilify (aripiprazole)*	*Haldol (haloperidol)*
Prolixin (fluphenazine)	*Clozaril (clozapine)*	*Risperdal (risperidone)*	*Fanapt (iloperidone)*	*Latuda (lurasidone)*
Sedative/Hypnotics				
Ambien (zolpidem)	*Lunesta (eszopiclone)*	*Sonata (zaleplon)*	*Rozerem (ramelteon)*	*Restoril (temazepam)*
Antianxiety medications				
Xanax (alprazolam)	*Ativan (lorazepam)*	*Klonopin (clonazepam)*	*Valium (diazepam)*	*Buspar (buspirone)*
ADHD medications				
Adderall (amphetamine)	*Concerta (methylphenidate)*	*Ritalin (methylphenidate)*	*Strattera (atomoxetine)*	*Vyvanse (lisdexamfetamine)*
Others				
Provigil (modafinil)	*Desyrel (trazodone)*	*Emsam (selegiline)*	*Savella (milnacipran)*	*Symbyax (fluoxetine/olanzapine)*

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

Yes	**No**		**Who?** (mother/ father/ children / siblings/ grandparents/aunts/uncles/cousins)
____	____	Depression	
____	____	Bipolar or Manic-Depressive disorder	
____	____	Anxiety	
____	____	ADHD	
____	____	Schizophrenia	
____	____	Alcohol abuse	
____	____	Other substance abuse	
____	____	Suicide attempt	

Medical History:

Primary Care Provider Name	Address	Phone

How long has your child been a patient with this provider? _____

Date of last appointment _____

Are immunizations up to date?:_____

Current Weight _____ Height _____

Has child had serious illnesses, injuries, surgeries, hospitalizations? _____

_____

_____

List any medications your child is **currently** taking (name of medication and dosage)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any food or medication allergies: _____

_____

Pharmacy: _____ Phone: _____

DEVELOPMENTAL HISTORY:

Was the pregnancy with this child desired? _____ Length of pregnancy: _____
Problems during pregnancy (include alcohol/drug usage by mother):_____

_____

Complications during delivery: _____
Explain if mother/child separated after birth: _____

_____

Other parent/child separations:_____
Describe child as an infant/toddler (cheerful, fussy, cuddly, withdrawn): _____

_____

Age child first sat up: _____ took steps: _____ spoke words: _____
Age first spoke in sentences: _____ weaned: _____ fed him/herself: _____
Age toilet-trained during day: _____ night: _____ problem now? _____
Age dressed self: _____ tied shoe-laces: _____ rode 2-wheel bike: _____
Age his voice changed (adolescent males): _____ developed body hair: _____
Age 1st menstruation (adolescent female): _____ breast development: _____

Social Information and Family Background:

Where was the child born? _____ Where has he/she lived? _____
Child was raised by: _____
Who lives in child's main household? _____

_____

Child's parents:
Father _____ Age _____
Mother _____ Age _____
Step-Parent _____ Age _____

What is the father's occupation? _____
What is the mother's occupation? _____

List Child's Brothers and Sisters and age (including half brothers and sisters and step brothers and sisters. If any of the the child's siblings are deceased, put down the name and the year of death in the Age column)

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/child relationship:

How do you and spouse/partner show affection to child? _____

_____

If one of child's biological parents is out of the home, describe his/her relationship with child: _____

_____

Responsibilities/rules: _____

_____

How does child handle these? _____
Has child threatened/attempted to run away or stayed out all night? _____
Explain: _____

What do you and your spouse/partner DO when your child misbehaves?
You: _____
Spouse/partner: _____
How do you and spouse/partner feel about using PHYSICAL DISCIPLINE?
You: _____
Spouse/partner: _____
Has family ever been involved with Protective Services? _____
When? _____ Reason: _____
Describe any BEHAVIOR of yourself, partner, or other adults in the home (drinking, drugs, verbal or physical conflict, suicide attempts, etc.) that may have affected your child: _____
_____
_____
_____
_____

Describe any EVENTS--family illness, death, separation, divorce, move to a different neighborhood or school, change in family finances, etc.-- that may have affected your child: _____
_____
_____

Employment/training/work hours of each parent/guardian:
You: _____
Spouse/partner: _____
ETHNIC/CULTURAL background of child: _____
RELIGIOUS/SPIRITUAL background: _____
LEGAL problems of child (past and present): _____
_____

SCHOOL: _____ Grade: _____
Address: _____ Phone: _____
Teacher: _____ Counselor: _____
In special classes?_____ If so, since what grade? _____
Learning disabilities? _____
Has child repeated any grades? _____ Which grades?_____
Describe attendance:_____
Describe effort/attitude toward school: _____
Describe academic performance: _____
Describe behavior in school:_____
When did school performance/behavior change?_____
Why do you think it changed? _____
Education of each parent/guardian: _____
_____

Is there anything else that you would like New Dimension Group to know?

_____
_____
_____
_____

Signature_____ **Date**_____

Emergency Contact _____ Telephone # _____

Reviewed by _____ Date _____
(Office use)

If child uses caffeine, tobacco, alcohol or drugs please complete following information

TYPE OF DRUG	AGE OF 1ST USE	WHAT AGE WAS CHILD USING IT REGULARLY	AVERAGE NUMBER OF DAYS USED EACH WEEK	ABOUT HOW MUCH WOULD CHILD USE EACH DAY	NUMBER DAYS USED IN PAST 30 DAYS	LAST DATE CHILD USED
Coffee Cola Caffeine pills						
Cigarettes						
Beer Wine Liquor						
Marijuana						
Crack cocaine Cocaine powder						
Heroin: Snort Shoot						
Methadone						
Pain Medication Type:						
Tylenol #3 or 4						
Muscle Relaxers Soma, Flexeril Other: _____						
Valium, Librium Other: _____						
Glue Poppers Aerosols						
PCP LSD Mescaline						
Meth-amphetamine						
Phenobarbital Sleeping pills						
Steroids						
Other:						