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Psychiatric Evaluation Intake Form- child and Adolescent

Please bring any supporting documents (i.e. pertinent medical records, results of prior treatment, psychological testing or school reports) to the first session. All responses are confidential. No information about you or your family will be released without your prior written consent. Thank you in advance for taking the time to provide this important information.

Patient's name:_________________________________ Age:___ Sex:___ Date: ___________
Legal Guardian:____
Guardian's phone Number: ____
Guardian's Address: ____
Patient's birthday: ___/___/______ Grade:_________
Others living in same house as patient (relationship/age):
____
____
____
Does child have siblings living outside of the home? Yes/No. If yes please provide name, ages, location.
____
____
____
Has there been a change in this patient's primary caregivers? Yes____ No_____
If yes, who was/were the caregiver(s) prior to this one, how long ago was there a change, and what was the reason for the change?
Prior caregiver(s)____
Dates:____________________________ Reason for change (i.e. divorce, death in the family, adoption)
Reason for referreal:____

Has this problem been treated before: Yes_____ No_____
If yes, what treatment modalities (i.e. individual, family therapy), including medications that have been tried in the past:
Past Medications: (name, dosage, effect positive or negative/side effects):
____
____
____

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Therapy: (dates, topics, effect):
____
____
____

Name(s) current/past mental health professionals:

Name:	Dates of treatment	phone number:
________________________________	______________	______________________
________________________________	______________	______________________
________________________________	______________	______________________

Current functioning:

Resent stressors: (i.e. death in family/move to new location, new medical illness):
____
____

Name of school: _______________________ How long has child attended that school? ________

Academic achievement: (above average, below average, average, specific problems)____
_________________ Has there there has been an Individual Educational Plan (IEP).

Approximate number of friends: ___________ Names of "best" friends__________________________
____

Child's favorite activities/hobbies:
____

What is child "best" at? (areas of strength):
____
____

What are areas that could be improved (areas of weakness)
____
____

What does child do when he/she is punished?
____
____

What does child do when he/she is mad?
____
____

What religion/ethnicity does family identify with?
____

Does child have difficulties related to religious or cultural identification?
____

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Please check any symptoms/problems below that apply to this child.

Symptoms/ problems	Current	Past	**Symptoms/ problems**	Current	Past
Difficulty with sleeping (falling asleep/staying asleep)	____	____	Does child think about one topic excessively?	____	____
With eating/appetite:	____	____	or do one activity over and over?	____	____
Loss of interest in activities/ frequently feeling bored	____	____	Is the child exposed to traumatic/life threatening situations?	____	____
Low self esteem/feeling guilty	____	____	Have violent dreams/nightmares	____	____
Loss of energy/frequent fatigue	____	____	Difficulty with fears/phobias	____	____
Thoughts of death/dying	____	____	Excessive concerns about weight	____	____
Unusual thoughts or behavior	____	____	Tics or recurrent involuntary movements	____	____
Seeing things others can not see	____	____	Difficulty with age appropriate interactions with peers	____	____
Hearing thing other can't hear	____	____			
Periods of excessive irritability	____	____	Excessive fights/conflicts with siblings	____	____
Excessively suspicious/fearful	____	____	Excessive conflicts with caregivers	____	____
Excessive boasting	____	____	Poor concentration	____	____
Inappropriate sexual behavior	____	____	Anxious/tearful	____	____
Problems with legal system/law	____	____	Difficulty with separations	____	____
Destruction of property	____	____	Excessive difficulty with public situations	____	____
Staying out late	____	____	Difficulty with gender/sexual orientation	____	____
Bullying other children	____	____	Substance use	____	____
Gang related activities	____	____	Alcohol	____	____
Frequent lying/stealing	____	____	Marijuana	____	____
Difficulty with sustained attention	____	____	Stimulants (cocaine, methamphetamine)	____	___
Hyperactive/"always on the go"	____	____	Other ______________________________	____	____

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Past Mental Health History:

Has this child ever intentionally hurt/cut him/herself? Yes __ No __ Ever attempt to kill him/herself? Yes/No ___

If yes, please briefly describe what happened and treatment(s) given:

____
____
____

Do you feel your child is in imminent danger of hurting or killing him/herself. Yes/No _______

Is your currently being treated with medications? Yes ___ No __

If yes, please list names, dosages, and length of treatment(s)

Medication	Dosages	Length of treatment
__________________	____	_____________________
__________________	____	_____________________

(If more space if needed please continue on back of page)

Past Medical History:

Does child have any current or past medical problems?

If yes, please list medical problems, year diagnosed, medications taken for the problem and primary physician treating medical condition (please list additional medication conditions on the back)

Medical Problem	Year Diagnosed	Current Medications	Physician/ contact number
________________________	______________	_________________________	______________
________________________	______________	_________________________	______________
________________________	______________	_________________________	______________

Past Medical History: (continued)

History of head trauma, loss or consciousness, seizures, or serious medical illnesses? Yes/no: ______

If yes, please briefly describe event(s) and treatments given:

____
____

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Please check if the patient has the following current (or recurrent) medical complaints

__ Headaches
__ Fever
___Numbness/weakness
___Difficulty walking
___Slurred speech
___Memory loss
___Visual problems
___Hearing problems
___ Chest pain

___ Abdominal pain
___ Difficulty walking
___ Recurrent cough
___ Tremors/dizziness
___ Joint pain
___Shortness of breath
___Difficulty urinating
___Difficulty defecating
___Excessive fatigue

___Rashes
___Food intolerance
___Diarrhea/constipation
___Allergies
___Frequent falls, injuries
___ Other aches/pains: If yes, please specify location(s)
____
___ Other symptoms:
____

If female, menstrual history:
Age of menarche ___________________ Date last menstrual period: _________
Cyclic mood symptoms: Yes ___ No____ Irregular/painful or heavy menses: ___________________

Family History:

Is there a family history (among biological relatives) of the following: clinical depression, anxiety, or unusual thoughts or behaviors?
If yes, please indicate disorder(s) and outcome of medications trials: effective, stopped due to side effects, etc.
_____________________________ _________________________________ ____________________________
____
____
Is there a family history of uncommon or rare medical disorders? Yes ___ No ___
If yes, what? ____
Did any biological relatives die due to medical (or unknown) causes at a young age? Yes ___ No __

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Child's Developmental History: (please check if yes)

____ Planned pregnancy
____ Difficulties during pregnancy
____ Exposure to alcohol/drugs during pregnancy
____ Difficulties during delivery
____ Feeding difficulties
____ Sleeping problems during infancy
____ Very sensitive to touch/sound
____ Cuddly, smiled at parents
____ Excessive difficulty with separation from caregivers

____ Medical illness as infant/toddler
____ Excessive temper tantrums
____ Difficulties/delays with walking
____ Difficulties/delay in talking
____ Difficulty calming down (self-soothing) when upset
_____ Any history of serious falls or loss of consciousness
_____ Is child able to swallow pills?
____ Did child attend preschool/ head start program

Age child said first words: ______ Able to walk _______________ Age slept along in room __________ Age patient was toilet trained: Bowel ______ Bladder _______ Does child still wet him/herself? _____ Has there ever been a loss of a previously obtained milestone (i.e has the child even been able to do something, like walk without assistance and then lost that ability) yes/no____