**CHILD/ADOLESCENT INTAKE INFORMATION FORM (Age 1-17)**

**Part I: Demographics Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Gender: |  | Date of Birth: |  | Age: |  | Education / Grade: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Ethnicity: |  | Religious Identity: |  | Sexual Orientation: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Adopted? |  | If yes, at age? |  | Are parents currently married/live together? |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Parents separated? |  | If yes, at age: |  | Divorced? |  | If yes, at age: |  |

|  |  |
| --- | --- |
| Full Address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Child/Adolescent Cell Phone (if applicable): |  | Home Phone: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Child/Adolescent Email: |  | Preferred Way(s) of Contact?: | Cell  Home  Email |

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|  |  |  |
| --- | --- | --- |
| Email Appointment Reminder: | No  Yes | If yes, who’s email?  Mom  Dad  Child/Adolescent |

|  |  |
| --- | --- |
| ***Referred By:*** | Google->Clinic Website  Facebook  Twitter  LinkedIn  PsychologyToday  Yelp |

|  |
| --- |
| International OCD Foundation (IOCDF) Directory  The TLC Foundation for BFRB Directory  Healthgrades |

|  |  |
| --- | --- |
| Anxiety & Depression Association of America (ADAA) Directory  Other online source: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Medical/Mental Health Professional (Specify): |  | Other: |  |

|  |  |  |
| --- | --- | --- |
| ***School*** | Name/Full Address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Teacher/Principal (Circle): |  | Email/Phone: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Psychologist/Nurse (Circle): |  | Email/Phone: |  |

|  |  |  |
| --- | --- | --- |
| ***Current Psychiatrist*** | Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Address: |  | Phone: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Fax Number: |  | Email: |  |

|  |  |  |
| --- | --- | --- |
| ***Current Primary Care Physician/Pediatrician*** | Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Address: |  | Phone: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Fax Number: |  | Email: |  |

**Part II: Parent/Caregiver/Guardian/Sibling Information**

|  |  |
| --- | --- |
| Who is/are the LEGAL guardian(s)? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Relationship to Patient: |  | Gender: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Birth: |  | Marital/Partner Status: |  | Ethnicity Identity: |  |

|  |  |
| --- | --- |
| Full Address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Cell Phone: |  | Home Phone: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Email: |  | Preferred Way(s) of Contact?: | Cell  Home  Work  Email |

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Occupation: |  | Income: |  | Work Phone: |  |

|  |  |
| --- | --- |
| Work Name & Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Relationship to Patient: |  | Gender: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date of Birth: |  | Marital/Partner Status: |  | Ethnicity Identity: |  |

|  |  |
| --- | --- |
| Full Address: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Cell Phone: |  | Home Phone: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Email: |  | Preferred Way(s) Contact?: | Cell  Home  Work  Email |

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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Occupation: |  | Income: |  | Work Phone: |  |

|  |  |
| --- | --- |
| Work Name & Address: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sibling Name:** |  | **Lives at Home?** |  | **Age:** |  | **School / Grade** |
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| --- | --- |
| **Others who live at home:** |  |

**THE FOLLOWING CAN BE COMPLETED BY THE PARENT OR THE TEEN.**

**Part III: Presenting Problems and Medication**

**Presenting Problem(s): Duration:**

**(e.g., home behavior/emotional, school behavioral/emotional/academic, community)**

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**Current Symptom Screening Checklist:**

**None**  This symptom not present at this time  **• Mild**  Impacts quality of life, but no significant impairment of day-to-day functioning

**Moderate (Mod)**  Significant impact on quality of life and/or day-to-day functioning  **• Severe**  Profound impact on quality of life and/or day-to-day functioning

None Mild Mod Severe None Mild Mod Severe None Mild Mod Severe

depressed mood     fear of other’s judgment     school refusal

appetite disturbance     separation anxiety     destruction of property

sleep problems     avoidance     oppositional behavior

elimination problems     laxative/diuretic abuse     aggressive behaviors

fatigue/low energy     anorexia     deceit/theft

bullied by others     bingeing/purging     serious rule violations

bully others     bodily concerns     significant weight gain/loss

poor grooming     eating/feeding challenges     sensitive to touch, sound, light

mood swings     paranoid ideation     emotional trauma victim

agitation/irritable     delusions     physical trauma victim

emotional     hallucinations     sexual trauma victim

elevated/manic mood     poor eye contact     stomachaches

excessive worry     grief     self-mutilation/harm to self

panic attacks     hopelessness     clingy

phobias     social isolation/online life     alcohol/drug use problems

obsessions/compulsions     worthlessness     tantrums (over 30 mintues)

health/death anxiety     hair pulling     headaches

hoarding     skin picking     guilt

tics     perfectionism     hypervigilant of surroundings

refuse to talk     feeling trapped     argumentative/hostile

poor concentration     attention problems     hyperactivity/imulsiveness

miss social cues     difficulty making friends     avoid social activities

**Current Medications:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Dose(mg)/day:** |  | **Prescribed for:** |  | **Prescribed by:** |
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**Part IV: Child’s Evaluation and Treatment History**

List in chronological order any evaluation done for any developmental, behavioral, or learning problems.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Dates** |  | **Clinic / Institution** |  | **Name & Profession** |  | **Type of Evaluation** |  | **Results /**  **Recommendations** |
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List in chronological order any outpatient help and/or hospitalization for any psychiatric or psychological problems.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Dates (from…to…)** |  | **Clinic / Institution** |  | **Name & Profession (e.g., psychologist, psychiatrist, counselor)** |  | **Reason for Therapy** |  | **Treatment Type (e.g., talk, CBT, medication)** |  | **Frequency (e.g., 1x/week, inpatient)** |
|  |  |  |  |  |  |  |  |  |  |  |
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**Part V: Family History**

Please note whether each relative has any of the following and whether they sought treatment for each.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Anxiety / Depression / Bipolar** | **Alcohol / Drug Abuse** | **Psychosis /**  **Schizophrenia** | **Attention /**  **Behavior / Conduct Problem** | **Learning Disabilities / Problems** | **Health Problems** |
| **Maternal** |  | | | | | |
| Grandmother |  |  |  |  |  |  |
| Grandfather |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |
| Aunt |  |  |  |  |  |  |
| Uncle |  |  |  |  |  |  |
| **Paternal** |  | | | | | |
| Grandmother |  |  |  |  |  |  |
| Grandfather |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |
| Aunt |  |  |  |  |  |  |
| Uncle |  |  |  |  |  |  |
| **Siblings** |  | | | | | |
| Brother |  |  |  |  |  |  |
| Sister |  |  |  |  |  |  |

**Part V: Health and Developmental History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Current physical health:** | Good | Fair | Poor | Date of last physical exam: |  |

|  |  |
| --- | --- |
| Date of first menstruation (if applicable): |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Asthma | Never | Past | Present | Surgery | Never | Past | Present |
| Adrenal (cortisol) problems | Never | Past | Present | Lengthy hospitalization | Never | Past | Present |
| Allergies | Never | Past | Present | Speech/language problem | Never | Past | Present |
| Strep throat / Mono | Never | Past | Present | Chronic ear infections | Never | Past | Present |
| Birth defects | Never | Past | Present | Hearing difficulties | Never | Past | Present |
| Diabetes/Hypoglycemia | Never | Past | Present | Eye/vision problems | Never | Past | Present |
| Hyperhidrosis (sweating problems) | Never | Past | Present | Fine motor/handwriting problems | Never | Past | Present |
| Pregnancy | Never | Past | Present | Gross motor difficulties | Never | Past | Present |
| Chicken pox | Never | Past | Present | Other sensory problems | Never | Past | Present |
| Heart disease | Never | Past | Present | Soiling problems | Never | Past | Present |
| High blood pressure | Never | Past | Present | Wetting problems | Never | Past | Present |
| High fevers (over 103**°**) | Never | Past | Present | Epilepsy/seizures | Never | Past | Present |
| Broken bones | Never | Past | Present | Cancer | Never | Past | Present |
| Severe cuts needing stitches | Never | Past | Present | Tuberculosis | Never | Past | Present |
| Head injury / loss consciousness | Never | Past | Present |  | Never | Past | Present |
| Lead poisoning | Never | Past | Present | Thyroid problems | Never | Past | Present |
| Other chronic illnesses: | Never | Past | Present | Other childhood illnesses: | Never | Past | Present |

**Developmental History:**

|  |  |  |  |
| --- | --- | --- | --- |
| Length of pregnancy (e.g., full term, 32 weeks, etc.) |  | Mother’s age when child was born: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Length of delivery (# of hours from initial labor pains to birth): |  | Child’s birth weight: |  |

Did any of the following conditions occur during pregnancy/delivery?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Bleeding | No | Yes | Delivery was induced | No | Yes |
| Excessive weight gain (> 30 lbs) | No | Yes | Forceps were used during delivery | No | Yes |
| Toxemia/preeclampsia | No | Yes | Had a breech delivery | No | Yes |
| Rh factor incompatibility | No | Yes | Had a cesarean section delivery | No | Yes |
| Frequent nausea or vomiting | No | Yes | Took illegal drugs | No | Yes |
| Serious illness or injury | No | Yes | Other problems: | No | Yes |
| Took prescription medications  a. If yes, name of medication: | No | Yes | Used alcoholic beverage  a. If yes, approximately number of drinks: | No | Yes |
| Smoked cigarettes  a. If yes, approximate number of cigarettes/day (e.g., ½ pack): | No | Yes | Was given medication to ease labor pains  a. If yes, name of medication: | No | Yes |

Did any of the following affect your child during delivery or within the first few days after birth?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Injured during delivery | No | Yes | Was jaundiced, turned yellow | No | Yes |
| Cardiopulmonary distress during delivery | No | Yes | Had an infection | No | Yes |
| Delivered with cord around neck | No | Yes | Had seizures | No | Yes |
| Had trouble breathing following delivery | No | Yes | Was given medications | No | Yes |
| Needed oxygen | No | Yes | Born with a congenital defect | No | Yes |
| Was cyanotic, turned blue | No | Yes | Was in hospital more than 7 days | No | Yes |

**Part V: Health and Developmental History (cont’d)**

During the first 12 months, was your child:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Difficult to feed | No | Yes | Difficult to get to sleep | No | Yes |
| Colicky | No | Yes | Difficult to put on a schedule | No | Yes |
| Alert | No | Yes | Cheerful | No | Yes |
| Affectionate | No | Yes | Sociable | No | Yes |
| Easy to comfort | No | Yes | Difficult to keep busy | No | Yes |
| Overactive, in constant motion | No | Yes | Very stubborn, challenging | No | Yes |

Did your child accomplish the following on time?

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Early** | **On Time** | **Late** |
| Sit without help |  |  |  |
| Walking along, without assistance |  |  |  |
| Putting two/more words together (e.g., “mama up”) |  |  |  |
| Crawling |  |  |  |
| Using single words (e.g., “mama,” “ball,” etc.) |  |  |  |
| Bowel training, day and night |  |  |  |

**Part VI: School History**

|  |
| --- |
| Academic challenges |
| Behavioral challenges (i.e.; defiance, doesn’t follow rules, difficulty with transitions etc.) |
| Emotional challenges (i.e.; separation anxiety, depression, withdrawn, poor boundaries, regulation issues etc.) |
| Social problems (i.e.; conflict with peers, difficulty sharing, lack of friends, etc.) |
| Aggression (i.e.; pushing, hitting, kicking, biting, etc.) |
| Difficulty complying with structure/routines of classroom |
| Developmental disability |
| In Special Education Classes |
| Expelled from preschool / childcare |
| At risk of being expelled |

|  |  |
| --- | --- |
| Does your child have an IEP?  yes  no  If yes, please give details: |  |

**Part VII: Psychological and Social Strengths**

Tell me about any abilities your child seems to have or any activities at which he/she is particularly good at (e.g., hobbies, sports, best subjects in school, games, and social activities)

**Part VIII: Parent Management Methods**

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

**History of Alcohol/Nicotine/Substance Use:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Substance(s) Used:** | **Yes** | **Age of First Use** | **Age of Last Use** | **How was it taken?** | **Amount per day** | **Days per month** |
| Alcohol (e.g., beer, cocktails, shots, hard liquor) |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |
| Nicotine (e.g., cigarettes, chewing tobacco) |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |
| Amphetamines (e.g., Speed, Methamphetamine, Phenmetraline, Khat, Betel nut, Ritaline, Methylphenidate) |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |
| Opiates (e.g., smoked heroin, Heroin, Opium) |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |
| Cocaine (e.g., Crack, Freebase, Coca leaves) |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |
| Hallucinogens (Ecstasy, LSD, Mescaline, Peyote, PCP, angel dust (Phencyclidine), Psilocybin, DMT (Dimethyltryptamine), bath salts |  |  |  |  |  |  |
| Solvents/Inhalants (e.g., glue, aerosols, thinner, trichloroethylene, gasoline/petrol, gas) |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |
| Cannabis (e.g., Marijuana, Hash, Hash oil) |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |
| Sleeping pills/Benzodiazepines (e.g., Valium, Klonopin, Ativan, Xanax)/pain killers |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |
| Other: |  |  |  | Oral  Nasal  Inhaled  Injected |  |  |

**Symptom Screener**

Please read the following statements and circle YES or NO to indicate whether each statement applies to your child. If you are unsure whether a statement applies, circle YES and ask your clinician about it.

**Yes No** 1. My child has frequent thoughts, urges, or images that he/she doesn’t want to have (for

example, thoughts about being contaminated even though they may not be, or that he/she may hurt someone else even though he/she doesn’t want to).

**Yes No** 2. My child does repetitive behaviors (for example, hand washing or cleaning, ordering or

arranging, checking things, or repeating behaviors over and over), or he/she repeatedly does things in his/her mind (for example, counting, saying certain words or phrases) in order to feel better or to prevent something bad from happening.

**Yes No** 3. My child spends a lot of time worrying about his/her body/physical appearance.

**Yes No** 4. My child’s room is excessively cluttered.

**Yes No** 5. My child frequently pulls out hair from his/her scalp or body.

**Yes No** 6. My child frequently picks at his/her skin.

**Yes No** 7. My child gets very anxious or fearful in social situations or when he/she is being observed

or evaluated.

**Yes No** 8. My child has had a panic attack, where he/she experienced a lot of fear and physical

sensations that came out of the blue.

**Yes No** 9. My child feels very fearful or anxious in situations where it’s difficult to escape quickly or

get help (for example, using public transportation, being in open or enclosed spaces, standing in line, being in a crowded place or being alone away from home).

**Yes No** 10. My child is excessively anxious or worried about many things, a lot of the time (for

example, worry about school, finances, being on time or not making mistakes, his/her health or the health of others).

**Yes No** 11. There are certain objects, situations, or activities that my child is very afraid of (for

example, animals, insects, blood, needles, heights, storms, flying, choking, vomiting, enclosed spaces, or costumed characters).

**Yes No** 12. My child is very afraid to be away from a certain person or people.

**Yes No** 13. My child has had a period of four days or more when his/her mood was so good or

elevated, like he/she was on top of the world, that it caused problems for him/her, or people thought he/she wasn’t his/her usual self.

**Yes No** 14. My child has been feeling down, blue, or depressed frequently over the past two years.

**Yes No** 15. My child has had a time when he/she felt very sad, blue, down, or depressed, or lost

interest or pleasure in his/her usual activities, for two weeks or more.

**Yes No** 16. (For females only) My child gets really depressed, irritable, anxious, or has mood swings

in the week prior to menstruation (her period).

**Yes No** 17. My child is distressed about a really bad event (like seeing something that was life-

threatening or caused someone to die, being seriously injuring or seeing someone be seriously injured, or being sexually assaulted or molested) that he/she has experienced or witnessed.

**Yes No** 18. My child is having a hard time dealing with a stressful or unpleasant experience, or a

major change in his/her life.

**Yes No** 19. My child has had very strong beliefs in something that other people thought were strange,

such as any of the following:

1. That people were conspiring against him/her, spying on him/her, or harassing him/her
2. That a governmental or religious organization was following him/her or harassing him/her
3. That someone he/she didn’t know, such as a celebrity, was in love with him/her
4. That he/she had special talents or powers, or that he/she was famous
5. That there was something very strange going on with his/her body
6. That someone had removed thoughts from his/her mind, placed thoughts in his/her mind, or read his/her mind
7. That someone or something was controlling his/her movements and actions
8. That someone was sending him/her special messages through the TV, radio, or books
9. That he/she did not exist, that the world did not exist, or that the world was ending
10. That he/she was responsible for a disaster or serious crime and needed to be punished

**Yes No** 20. My child has had sensory experiences that others could not understand, such as:

1. Hearing sounds that others couldn’t hear, such as voices or music
2. Seeing things that others couldn’t see, such as colors, animals, people or spirits
3. Having unusual sensations in his/her body, such as a feeling of electric shocks or bugs on him/her
4. Smelling odors that others could not smell, such as vomit, feces, or something rotting

**Yes No** 21. My child avoids eating food because he/she thinks he/she is overweight.

**Yes No** 22. My child often has eating “binges,” in which he/she eats more than most people would

eat, and it feels like his/her eating is out of control.

**Yes No** 23. My child eats very little, has difficult eating enough, or avoids certain foods.

**Yes No** 24. My child has a physical health problem that makes him/her very worried or anxious, or

requires him/her to do a lot to diagnose or monitor it.

**Yes No** 25. My child often worries that he/she has a serious medical illness or injury, or that he/she

is going to develop a serious medical illness or injury.

**Yes No** 26. My child has difficulty paying attention or concentrating when he/she needs to.

**Yes No** 27. It often seems that my child has difficulty sitting still or waiting for things.

**Yes No** 28. My child has a lot of sudden movements (tics) that are hard to control, or makes sounds

that are hard to control.