Child/Teen Intake Form

Patient's Name ____ DOB ________________

Primary Care Physician _____________________________ Therapist ________________________

Current Symptoms Checklist:

☐ Depressed mood ☐ Racing thoughts ☐ Excessive worry ☐ Unable to enjoy activities ☐ Impulsivity ☐ Anxiety attacks ☐ Sleep pattern disturbance ☐ Increase risky behavior ☐ Avoidance ☐ Loss of interest ☐ Hallucinations ☐ Concentration/forgetfulness ☐ Decrease need for sleep ☐ Change in appetite ☐ Excessive energy ☐ Excessive guilt ☐ Increased irritability ☐ Fatigue ☐ Crying spells ☐ Other_______________

Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No

Do you currently feel that you don't want to live? ☐ Yes ☐ No

Have you ever tried to kill or harm yourself before? ☐ Yes ☐ No

Current Medications:

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Reason

Current over-the-counter medications or supplements:

____

____

____

____

____

Past Psychiatric History

Have you ever participated in outpatient treatment? ☐ Yes ☐ No. If yes, please describe when, by whom, and nature of treatment.

____

____

____

____

Do you have a history of past psychiatric hospitalization? ☐ Yes ☐ No. If yes, describe for what reason, when and where.

____

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____

____

Past Psychiatric Medications:

Antidepressants: ____

Antipsychotics: ____

Mood Stabilizers: ____

Sedative/Hypnotics: ____

ADHD Medications: ____

Antianxiety medications: ____

Other: ____

Family Psychiatric History:

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

Bipolar disorder ☐ Yes ☐ No

Schizophrenia ☐ Yes ☐ No

Depression ☐ Yes ☐ No

Post-traumatic stress ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Alcohol/Substance abuse ☐ Yes ☐ No

Anger ☐ Yes ☐ No

Suicide ☐ Yes ☐ No

Violence ☐ Yes ☐ No

If yes, who had what problems?

____

____

____

Developmental History:

Pregnancy

Normal pregnancy? ☐ Yes ☐ No

If problems, please describe: ____

During pregnancy, did mother use any of the following?

Medications? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No

Tobacco? ☐ Yes ☐ No Illicit drugs? ☐ Yes ☐ No

Labor & Delivery

Full Term? ☐ Yes ☐ No Labor: ☐ Easy ☐ Difficult

Baby's presentation? ☐ Head first ☐ Breech Delivery? ☐ Vaginal ☐ C-section

Birth weight? ___ lbs _____ oz

Following delivery, did your child…

Need supplemental oxygen? ☐ Yes ☐ No Need blood transfusion? ☐ Yes ☐ No

Need X-rays, CT, or MRI? ☐ Yes ☐ No Have other complications? ☐ Yes ☐ No

Newborn Period

Did your child exhibit the following? How long?

Irritability ☐ Yes ☐ No___________

Vomiting ☐ Yes ☐ No ___________

Convulsions/Seizures ☐ Yes ☐ No _____________

Difficulty Breathing ☐ Yes ☐ No ___________

Breastfeeding ☐ Yes ☐ No ____________

Normal weight gain ☐ Yes ☐ No ____________

Development

Any concerns your child was delayed in development? ☐ Yes ☐ No

	Age		Age		Age
Sitting without help		Spoke single words		Weaned	
Crawling		Spoke in sentences		Bladder Trained	
Walking		Puberty		Bowel Trained	

Education

Has your child had specific learning difficulties? ☐ Yes ☐ No

Has your child undergone testing to evaluate? ☐ Yes ☐ No

Has your child ever skipped a grade? ☐ Yes ☐ No

Repeated a grade? ☐ Yes ☐ No

	Name of School:	Grades Completed:
Preschool		
Elementary		
Middle School		
High School		