Therapies 4 Kids
Exceptional Care For Exceptional Children

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Psych-4U
HELPING PATIENTS FROM ALL WALKS OF LIFE

PSYCHIATRIC SERVICES
CHILD/ADOLESCENT INTAKE FORM

Coming to a therapy clinic for the first time can be overwhelming and confusing. Here at Therapies 4 Kids, we are committed to make this experience as easy and comforting as possible. Please understand the importance of filling out this questionnaire. The information requested below is necessary for us to identify your child's needs and how to best serve your family.

We have shortened our form to make this task as easy as possible for you and appreciate your compliance. After reviewing this initial intake form, we may ask that you provide additional information necessary to develop the best Plan of Care for your family member.

It is essential that we receive a completed form prior to our first visit. Please be prepared to arrive 30 minutes early to complete clinical paperwork upon arrival.

Please, bring your completed paperwork, updated insurance information and any current medication in their original bottle. Take your time to complete past medical history, education setting and background information, so we can best meet your family member's needs.
All information provided on this form is strictly confidential.

Thank you for choosing Psych 4 U

We are looking forward to meeting you!

Office use

Date: ___ / ___ / _____ (mm / dd / yyyy)

Psychiatrist: _____

Comments: _____

GENERAL INFORMATION

Child's full name: _____ Preferred Name: _____

D.O.B: ___ / ___ / _____ (mm / dd / yyyy) Age: _____

Gender: ☐ M ☐ F

Ethnicity: _____ Religion: _____

Physician's name: _____ Physician's Phone: _____

Psychiatrist's name: _____ Psychiatrist's Phone: _____

Parent/Care Giver name: _____

Address: _____

City: _____ State: ____ Zip code: _____ Country: _____

Home phone: _____ Work phone: _____ Cellphone: _____

E-mail address: _____

AREAS OF CONCERN

Does your child currently have any of the following problems? (Tick all that apply)

Personal/Social Adjustment

- ☐ Overly anxious
- ☐ Overly aggressive
- ☐ Temper tantrums
- ☐ Withdrawn or shy
- ☐ Disturbing habits or mannerisms
- ☐ Strange or bizarre behavior
- ☐ Problems in peer relationships
- ☐ Drug or alcohol problems
- ☐ Problems with the law
- ☐ Harms self or others (suicidal or homicidal)
- ☐ Others (please specify)

School Adjustment

- ☐ Academic problems
- ☐ Difficulty with peers
- ☐ Difficulty with authority
- ☐ Attendance problems or reluctance to go to school
- ☐ Behavior problems
- ☐ Learning disabilities
- ☐ Attentional problems
- ☐ Aches and pains related to school
- ☐ Others (please specify)

Family Adjustment

- ☐ Parent-child problems
- ☐ Marital conflict or coparenting problems
- ☐ Sibling conflict
- ☐ Recent family changes
- ☐ Neighborhood difficulties
- ☐ Mother experiencing difficulties
- ☐ Father experiencing difficulties
- ☐ Sibling experiencing difficulties
- ☐ Drug or alcohol problems in family
- ☐ History of trauma or loss
- ☐ Domestic violence
- ☐ Abuse
- ☐ Others (please specify)

Physical/Developmental Factors

- ☐ Eating
- ☐ Sleeping
- ☐ Toileting
- ☐ Grooming
- ☐ Language or speech
- ☐ Perceptual/visual functions
- ☐ Motor coordination problems
- ☐ Others (please specify)

HISTORY OF CURRENT PROBLEM

Duration and primary concern (include changes in mood, behavior, sleep, eating, free time activities, school concerns):

What have you already done to address this concern and how effective were these efforts?

Was there an event that caused you to seek treatment now? ☐ Yes ☐ No If yes, please describe:

SYMPTOMS

Please tick all of the following symptoms that apply to your child:

- ☐ Sad or depressed mood
- ☐ Loss of interest in activities or hobbies
- ☐ Feeling hopeless about the future
- ☐ Change in appetite
- ☐ Withdrawn from family or friends
- ☐ Feelings of guilt or worthlessness
- ☐ Sleep disturbance
- ☐ Low energy or fatigue

SYMPTOMS *(continued)*

- ☐ Trouble focusing or concentrating
- ☐ Thoughts of suicide
- ☐ Irritability
- ☐ Worrying too much
- ☐ Muscle tension
- ☐ Fear of looking stupid or being embarrassed
- ☐ Any other fears or phobias
- ☐ Episodes of decreased need for sleep
- ☐ Racing thoughts
- ☐ Overly happy or euphoric
- ☐ Thoughts, feelings or pictures that come into the child's mind even if he/she does not want them to
- ☐ Hearing voices that other people cannot hear
- ☐ Feeling paranoid
- ☐ Poor body image
- ☐ Intentionally throwing up after eating
- ☐ Easily annoyed
- ☐ Argues with authority figures
- ☐ Blaming others for his/her mistakes
- ☐ Lying
- ☐ Destroying property
- ☐ Skipping school
- ☐ Difficulty learning
- ☐ Difficulty forming or keeping friendships
- ☐ Tics, twitches or involuntary movements
- ☐ Thoughts of hurting self
- ☐ Thoughts of hurting or killing others
- ☐ Severe angry outbursts (verbal or physical)
- ☐ Feeling or acting restless
- ☐ Panic or anxiety attacks
- ☐ Fear of offending others
- ☐ Drastic mood swings
- ☐ Extreme hyperactivity
- ☐ Talking so fast it's hard to understand
- ☐ Overly confident
- ☐ Habits the child feels they must do even if he/she knows it does not make sense (for example excessive cleaning, checking, repeating, counting, organizing or hoarding things)
- ☐ Seeing things other people cannot see
- ☐ Odd thinking or beliefs
- ☐ Trying to lose weight even though he/she is not overweight
- ☐ Easily loses temper
- ☐ Defiant
- ☐ Annoying others on purpose
- ☐ Resentful, spiteful or vindictive
- ☐ Stealing
- ☐ Setting fires
- ☐ Hurting other people or animals
- ☐ Trouble understanding social cues
- ☐ Being very sensitive to sound, light, touch or smell
- ☐ Making involuntary sounds

Traumatic experiences

Has your child ever been exposed to actual or threatened death, serious injury, or sexual violence? ☐ Yes ☐ No

If yes, does he/she have any of the following symptoms related to the traumatic event?

- ☐ Upsetting or intrusive memories
- ☐ Flashbacks (feeling/acting like the event is happening again)
- ☐ Feeling upset by reminders of the event
- ☐ Feeling like the world/surroundings are not real
- ☐ Recklessness or self-destructive behavior
- ☐ Always looking around for signs of danger
- ☐ Nightmares
- ☐ Avoiding talking or thinking about what happened
- ☐ Having out of body experiences
- ☐ Angry outbursts
- ☐ Getting startled very easily
- ☐ Trouble remembering some or all of what happened

PAST PSYCHIATRIC HISTORY

Has your child ever seen **a psychiatrist or therapist/counselor** before?

Name of Provider	Dates	Reason

Has your child ever been admitted to **a psychiatric hospital**?

Name of Hospital	Dates	Reason

Has your child ever attempted suicide? ☐ Yes ☐ No If yes, please describe:

Does your child engage in any self-harm behaviors (like cutting)? ☐ Yes ☐ No If yes, please describe:

Has your child ever been violent or aggressive? ☐ Yes ☐ No If yes, please describe:

Please list any known psychiatric illnesses in **blood relatives** of the child:

Psychiatric Illness	Child's Mother	Child's Father	Child's Sibling	Mother's side of the family	Father's side of the family
Depression					
Anxiety					
Bipolar Disorder					
Psychosis					
Schizophrenia					
ADHD					
Intellectual disability or learning problems					
Autism					
Eating disorder					
Alcohol problems					
Drug problems					
Suicide					

MEDICAL HISTORY

Does your child have any history of the following medical conditions? (Tick all that apply)

- ☐ Allergies: _____ (Please describe)
- ☐ Asthma
- ☐ Respiratory Illness
- ☐ Diabetes
- ☐ Convulsions/Seizures/Epilepsy
- ☐ Head Injury
- ☐ Dizziness or Fainting
- ☐ Loss of Consciousness
- ☐ Heart problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Urogenital Problems
- ☐ Vision Problems
- ☐ Hearing problems

Other serious illness or disease: _____

Chronic condition or disability: _____

Has your child ever had surgery? ☐ Yes ☐ No If yes, please describe and give dates:

_____

_____

Has your child ever had any serious injuries? ☐ Yes ☐ No If yes, please describe and give dates:

_____

_____

Biological females only

Has your child started menstruation? ☐ Yes ☐ No If yes, at what age? _____ Are periods regular? ☐ Yes ☐ No

Date of last menstrual cycle: ___ / ___ / _____ (mm / dd / yyyy) Is there any change in symptom severity with periods? ☐ Yes ☐ No

If yes, please describe: _____

Medications of any kind your child is currently taking:

Medication	Dosage	Frequency	Purpose	Who prescribes it

Describe any allergies your child may have to medications:

_____

_____

Medications your child as taken in the past: (Tick all that apply)

☐ Alprazolam (Xanax)	☐ Amitriptyline (Elavil)	☐ Amphetamine (Adderall)
☐ Aripiprazole (Abilify)	☐ Asenapine (Saphris)	☐ Atomoxetine (Strattera)
☐ Bupropion (Wellbutrin)	☐ Buspirone (BuSpar)	☐ Carbamazepine (Tegretol)
☐ Citalopram (Celexa)	☐ Clomipramine (Anafranil)	☐ Clonazepam (Klonopin)
☐ Clonidine (Kapvay)	☐ Clozapine (Clozaril)	☐ Desipramine (Norpramin)
☐ Desvenlafaxine (Pristiq)	☐ Dexmethylphenidate (Focalin)	☐ Diazepam (Valium)
☐ Duloxetine (Cymbalta)	☐ Escitalopram (Lexparo)	☐ Fluoxetine (Prozac)
☐ Fluphenazine (Prolixin)	☐ Fluvoxamine (Luvox)	☐ Guanfacine (Intuniv)
☐ Haloperidol (Haldol)	☐ Iloperidone (Fanapt)	☐ Imipramine (Tofranil)
☐ Lamotrigine (Lamictal)	☐ Levomilnacipran (Fetzima)	☐ Lisdexamfetamine (Vyvanse)
☐ Lithium	☐ Lorazepam (Ativan)	☐ Loxapine (Loxitane)
☐ Lurasidone (Latuda)	☐ Methylphenidate (Aptensio, Concerta, Daytrana, Metadate, Methylin, Ritalin, Quillivant)	☐ Mirtazapine (Remeron)
☐ Nortriptyline (Pamelor)	☐ Olanzapine (Zyprexa)	☐ Oxcarbazepine (Trileptal)
☐ Paliperidone (Invega)	☐ Paroxetine (Paxil)	☐ Quetiapine (Seroquel)
☐ Risperidone (Risperdal)	☐ Sertraline (Zoloft)	☐ Topiramate (Topamax)
☐ Trazodone (Desyrel)	☐ Valproic Acid (Depakote)	☐ Venlafaxine (Effexor)
☐ Vilazodone (Viibryd)	☐ Vortioxetine (Brintellix)	☐ Ziprasidone (Geodon)

Others: _____

SUBSTANCE USE & HABITS

(Please list amount and frequency)

Illegal drugs: _____ Alcohol: _____

Tobacco: _____ Caffeine: _____

Vitamins: _____ Herbal supplements: _____

Sleep: _____ Eating: _____

Exercise (amount/type/frequency): _____

Other: _____

FAMILY & HOUSEHOLD

Is the child adopted: ☐ Yes ☐ No If yes, is the child aware? ☐ Yes ☐ No

Parents Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

Father's occupation: _____ Mother's occupation: _____

Divorced/separated parents

If divorced, what are the custody arrangements? _____
(Please bring copy of custody agreement)

Other parent's name: _____

Other parent's address: _____

_____

City: _____ State: ____ Zip code: _____ Country: _____

Home phone: _____ Work phone: _____ Cellphone: _____

E-mail address: _____

HOUSEHOLD MEMBERS

Name	Sex	Age	Relationship

FAMILY MEMBERS NOT LIVING IN HOUSEHOLD (e.g. stepchildren, adult children, etc.)

Name	Sex	Age	Relationship

SCHOOL HISTORY

Current grade: _____ Current school: _____

School address: _____

City: _____ State: ____ Zip code: _____ Teacher: _____

School phone: _____ School email: _____

Did the child repeat any grades? ☐ Yes ☐ No

Has the child ever been suspended or expelled? ☐ Yes ☐ No

Does the child have a 504 plan or IEP? ☐ Yes ☐ No

Is the child in ESE or Special Needs class? ☐ Yes ☐ No

Has the child ever been evaluated? ☐ Yes ☐ No

If yes, please specify:

Type of Evaluation	Date	Evaluator (name & phone)	Outcome

DEVELOPMENTAL HISTORY

A. PRENATAL HISTORY

Mother's health during pregnancy: ☐ Good ☐ Fair ☐ Poor

Age of mother at child's birth: ☐ Under 20 ☐ 20-24 ☐ 25-29 ☐ 30-34
☐ 35-39 ☐ 40-44 ☐ Over 44 ☐ Unknown

Did mother use any of these substances or medications during pregnancy?

Beer/Wine:	☐ Never	☐ Once or twice	☐ 3-9 times	☐ 10-19 times	☐ 20-39 times	☐ 40+ times
Coffee/Caffeine:	☐ Never	☐ Once or twice	☐ 3-9 times	☐ 10-19 times	☐ 20-39 times	☐ 40+ times
Hard Liquor:	☐ Never	☐ Once or twice	☐ 3-9 times	☐ 10-19 times	☐ 20-39 times	☐ 40+ times
Tobacco:	☐ Never	☐ Once or twice	☐ 3-9 times	☐ 10-19 times	☐ 20-39 times	☐ 40+ times
Tranquilizers (sleeping pills):	☐ Never	☐ Once or twice	☐ 3-9 times	☐ 10-19 times	☐ 20-39 times	☐ 40+ times
Other _____ (Specify)	☐ Never	☐ Once or twice	☐ 3-9 times	☐ 10-19 times	☐ 20-39 times	☐ 40+ times

Did mother have toxemia or eclampsia? ☐ Yes ☐ No

Was there Rh factor incompatibility? ☐ Yes ☐ No

Was child born on schedule? ☐ Yes ☐ No If early, how premature: _____

Duration of labor: _____ Fetal distress during labor? ☐ Yes ☐ No

Was delivery: ☐ Normal ☐ Breech ☐ Caesarian ☐ Forceps ☐ Suction ☐ Induced

Child's birth weight: _____ APGAR Score: _____

Were there complications following birth? ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

_____

B. POSTNATAL PERIOD / INFANCY / TODDLER

Feeding problems? ☐ Yes ☐ No Colic? ☐ Yes ☐ No

Sleep pattern difficulties? ☐ Yes ☐ No Problems with responsiveness (alertness)? ☐ Yes ☐ No

Were there health or congenital problems during infancy? ☐ Yes ☐ No

How was it to care for this child? ☐ Very easy ☐ Easy ☐ Average ☐ Difficult ☐ Very ifficult

How did the child behave with other people?

☐ More sociable than average ☐ Average sociability ☐ More unsociable than average

When the child wanted something, how insistent was he/she?

☐ Very insistent ☐ Somewhat insistent ☐ Average ☐ Not very insistent ☐ Not insistent at all

Rate the activity level of the child:

☐ Very ctive ☐ Active ☐ Average ☐ Less active ☐ Not active

C. DEVELOPMENTAL MILESTONES

Age child sat up: ☐ 3-6 months ☐ 7-12 months ☐ Over 12 months

Age child crawled: ☐ 6-12 months ☐ 13-18 months ☐ Over 18 months

Age child walked alone: ☐ Under 1 year ☐ 1-2 years ☐ 2-3 years

Age child spoke single words other than 'mama' or 'dada'?

☐ 9-13 months ☐ 14-18 months ☐ 19-24 months ☐ 25-36 months ☐ 37-48 months

Age child strung two or words together:

☐ 9-13 months ☐ 14-18 months ☐ 19-24 months ☐ 25-36 months ☐ 37-48 months

Age toilet trained:

Bladded controlled: ☐ Under 1 year ☐ 1-2 years ☐ 2-3 years ☐ 3-4 years ☐ 4+ years

Bowel controlled: ☐ Under 1 year ☐ 1-2 years ☐ 2-3 years ☐ 3-4 years ☐ 4+ years

How long did toilet training take from onset to completion?

☐ Less than 1 month ☐ 1-2 months ☐ 2-3 months ☐ More than 3 months

Who referred you to our clinic? _____

Signature:

Date: ___ / ___ / _____
mm dd yyyy

Printed name: _____ Relationship to patient: _____