

## Child/Adolescent Psychiatric Intake Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

PCP: \_\_\_\_\_ Home Phone#: \_\_\_\_\_

Cell phone #: \_\_\_\_\_ Email address: \_\_\_\_\_

Current therapist/Counselor: \_\_\_\_\_

Pharmacy (Name and cross streets): \_\_\_\_\_

Who referred you to our clinic today?

What are the issues/symptoms that brings you into the clinic today?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What are your treatment goals? \_\_\_\_\_

### **Circle Current Symptoms:**

Makes careless mistakes

Repetitive behaviors or tics

Difficulty sustaining attention

Difficulty focusing

Difficulty organizing tasks

Loses things easily

Easily distracted by external stimuli

Fidgety unable to sit still

Blurts out answer

Interrupts others

Difficulty with math/reading/writing

Speech or language problems

Talks excessively

Truancy

Has run away from home

Loses temper easily

Angry/resentful

Argues with authority

Defies or refuses to comply with rules

Deliberately annoys others

Spiteful/vindictive	Blames others for own mistakes
Behavioral outbursts (physical or verbal)	Bullies or threatens others
Cruelty to animals	Stealing/shoplifting
Separation anxiety (home, other figures)	Fear of certain situations
Fear of speaking in social situations (school, stage)	
Depressed/sad	Worries about different things
Increased/decreased appetite	Increased/decreased sleep
Increased/decreased energy	Excessive worry about things
Feeling worthless or hopeless	Feeling guilty
Little interest or pleasure in activities	Obsessive thoughts
Fire setting	Increased talkativeness
Inflated self-esteem	Racing thoughts

**Suicide Risk Assessment:**

Have you ever had feelings or thoughts that you did not want to live? YES or NO

Do you currently feel that you do not want to live? YES or NO

How often do you have these thoughts? \_\_\_\_\_

When was the last time you had thoughts of dying? \_\_\_\_\_

Has anything happened recently to make you feel this way? \_\_\_\_\_

On a scale of 1 to 10, (ten being the strongest) how strong is your desire to kill yourself currently? \_\_\_\_\_

Would anything make it better? \_\_\_\_\_

Have you ever thought about how you would kill yourself? \_\_\_\_\_

Is the method you would use readily available? \_\_\_\_\_

Have you planned a time for this? \_\_\_\_\_

Is there anything that would stop you from killing yourself? \_\_\_\_\_

Have you ever tried to kill or harm your self before? \_\_\_\_\_

**Medical History:** (please list all the past and present medical conditions that you have been diagnosed and treated for? \_\_\_\_\_  
 \_\_\_\_\_

**Allergies** (*medication, food or environmental*):  
 \_\_\_\_\_

**List Current Medications (Prescription and non-prescription):**

Medication Name	Dose	How often do you take it?	Estimated Start Date

**Past Psychiatric Medications: (Please circle the medication if taken in the past):**

**Antidepressants**

Prozac (fluoxetine)	Celexa (citalopram)	Effexor (venlafaxine)
Luvox (fluvoxamine)	Lexapro (escitalopram)	Viibryd (vilazodone)
Paxil (paroxetine)	Wellbutrin (bupropion)	Anafranil (clomipramine)
Cymbalta (duloxetine)	Remeron (mirtazapine)	Pamelor (nortriptyline)
Tofranil (imipramine)	Elavil (amitriptyline)	Pristiq (desvenlafaxine)
Brintellix/Trintellix (vortioxetine)		

**Mood Stabilizers**

Tegretol (carbamazepine)	Lithium	Depakote (valproate)
Trileptal (oxcarbazepine)	Keppra (levetiracetam)	Neurontin (gabapentin)
Topamax (topiramate)		

**Antipsychotic Medications**

Haldol (haloperidol)	Navane (thiothixene)	Prolixin (fluphenazine)
Thorazine (chlorpromazine)	Abilify (aripiprazole)	Seroquel (quetiapine)
Clozaril (clozapine)	Zyprexa (olanzapine)	Geodon (ziprasidone)
Risperdal (risperidone)	Inapsine (droperidol)	Fanapt (iloperidone)
Latuda (lurasidone)	Invega (paliperidone)	Saphris (asenapine)

**ADHD Medications**

Adderall (amphetamine)	Concerta (methylphenidate)	Ritalin (methylphenidate)
Strattera (atomoxetine)	Vyvanse (lisdexamfetamine)	Dexedrine (amphetamine)
Intuniv/ Tenex (guanfacine)		

**Anti-anxiety Medications**

Xanax (alprazolam)	Ativan (lorazepam)	Klonopin (clonazepam)
Valium (diazepam)	Tranxene (clorazepate)	Buspar (buspirone)
Neurontin (gabapentin)	Vistaril (hydroxyzine)	

**Sleep Medications**

Ambien (zolpidem)	Restoril (temazepam)	Seroquel (quetiapine)
Sonata (zaleplon)	Desyrel (trazadone)	Vistaril (hydroxyzine)
Rozerem (ramelteon)	Lunesta (eszopiclone)	Neurontin (gabapentin)

Other Psychiatric Medications:

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**Child's Medical and Family Medical History** *(Have you or a family member ever had any of the following? If family, specify which family member)*

	You	Family	Which family member?
Thyroid disease			
Anemia			
Liver problems/hepatitis			
Kidney problems			
Diabetes			
Asthma			

Stomach or intestinal problems			
Cancer			
Chronic pain			
Heart disease			
Epilepsy/seizures			
High cholesterol			
High blood pressure			
Head injury			
Lung disease			
Sleep apnea			
Stroke			
Neurological Problems			
Skin problems			
Other:			

**List Past Surgical History:**

Type of Surgery	Year

**For Females Only:**

Date of last menstrual period? \_\_\_\_\_

Are you currently pregnant or do you think you might be pregnant? YES or NO

Current birth control method: \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_

How many live births? \_\_\_\_\_

Any miscarriages/ ectopic pregnancy/still births? \_\_\_\_\_

**Developmental History**

Any problems during your mother's pregnancy with you? (please circle)

None    High blood pressure    Kidney infection    Emotional stress

Bleeding    Alcohol use    Drug abuse    Cigarette use

Other: \_\_\_\_\_

**Birth:**  Normal  C-section  Other

Did you have any developmental delays? (such as rolling over, sitting, crawling, speaking, standing, walking, toileting, controlling bladder or bowels etc): \_\_\_\_\_

\_\_\_\_\_

**Past Psychiatric History**

	You	Family	Which family member?
Depression			
Anxiety			
Bipolar I/ Bipolar II			
ADHD			
Suicide			
Schizophrenia			
PTSD			
Alcohol problems			
Drug problems			
Other			

Have you had prior psychiatric **outpatient** treatment?

Reason	Dates Treated	By whom and where?

Have you had prior **inpatient** treatment? (hospitalization, intensive outpatient treatment, substance abuse treatment?)

Reason	Dates Admitted	Where?

**Substance Use History**

No history of substance use

	YES	NO	If YES, how long and when did you last use?
Alcohol			
Tobacco			
Vape			
Methamphetamines			
Cocaine			
Stimulants			
Heroin			
LSD or Hallucinogens			
Marijuana			
Pain killers/Narcotics			
Methadone			
Chronic pain			
Tranquilizers/ sleeping pills			
Ecstasy			
Other:			

How many cups caffeinated beverages do you drink a day?

Coffee: \_\_\_\_\_ Sodas: \_\_\_\_\_ Tea: \_\_\_\_\_ Other: \_\_\_\_\_

**Tobacco History**

Have you ever smoked cigarettes?  YES  NO

Currently?  YES  NO How many packs per day on average? \_\_\_\_\_.

How many years? \_\_\_\_\_

In the past?  YES  NO. How many years did you smoke? \_\_\_\_\_. When did you quit? \_\_\_\_\_

Pipe, cigars, or chewing tobacco? Currently?  YES  NO In the past?  YES  NO

**Social History**

Current living situation (home, apartment): \_\_\_\_\_

Who do you live with? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

Who is your support system? \_\_\_\_\_

Do you currently work or involved in any extracurricular activities?

**Family Background**

Were you adopted?  YES  NO

Where did you grew up? \_\_\_\_\_

Who raised you? \_\_\_\_\_

List your siblings and their ages? \_\_\_\_\_

Are your parents alive or deceased? \_\_\_\_\_

Father's occupation? \_\_\_\_\_ Mother's occupation: \_\_\_\_\_

Did your parents divorce?  YES  NO. If yes, how old were you when they divorced? \_\_\_\_\_

Whom did you live with after your parents divorced? \_\_\_\_\_

How is your relationship with your father? \_\_\_\_\_

How is your relationship with your mother? \_\_\_\_\_

**Your Exercise Level**

Do you exercise regularly?  YES  NO

How often do you exercise? \_\_\_\_\_

What type of exercise do you do? \_\_\_\_\_

**Educational History**

Which school do you currently attend? \_\_\_\_\_

Current grade? \_\_\_\_\_

Are you currently having any difficulties at school?  Yes  No

Are you receiving any special services at school? (IEP, counseling, special Ed, speech or language therapy, gifted/accelerated classes)?  Yes  No

**Trauma History**

Do you have a history of being abused emotionally, sexually, physically or by neglect?  YES  NO

Please describe when, where and by whom? \_\_\_\_\_

**Relationship/ Sexual History**

Are you currently in a relationship?  Yes  No

Do you feel safe in your relationship?  Yes  No

Are you sexually active?  Yes  No

How do you identify your sexual orientation?  Heterosexual  Homosexual  Bisexual

Transsexual  Other



**Legal History**

Have you ever gotten into any trouble with the law?  YES  NO

**Hobbies**

Do you have any hobbies? If yes, what are they?

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Is there anything else that you would like your psychiatric provider to know?

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