



PsychNP Wellness Center, LLC

## New Patient Ages 2-17 Behavioral Health Intake Form

### ABOUT YOUR CHILD

- Child's Name: \_\_\_\_\_
- Preferred Name: \_\_\_\_\_
- Date of Birth: \_\_\_\_\_
- Pronouns (if applicable): \_\_\_\_\_

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### CAREGIVER INFORMATION

Child currently lives with:

- Biological Mother    Biological Father    Stepmother    Stepfather  
 Adoptive Mother    Adoptive Father    Foster Mother    Foster Father  
 Grandmother    Grandfather    Other  
(specify) \_\_\_\_\_

*(A copy of legal custodianship needs to be provided if child is cared for by person(s) other than living biological or adoptive parents)*

Marital Status of Parents:

- Married (for \_\_\_\_\_ years)    Never Married    Separated    Divorced    Widowed

**Mother's name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

Currently employed:  No  Yes, as: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_

**Father's name:** \_\_\_\_\_ **Birth date:** \_\_\_\_\_

Cell phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

Currently employed:  No  Yes, as: \_\_\_\_\_

Highest grade completed: \_\_\_\_\_

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**Siblings:** Names, gender, and ages of siblings (please specify if a half or step-sibling)

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**WHAT ARE YOUR MAIN CONCERNS?**

**What brings you in today? (check all that apply):**

- Attention/focus concerns
- Anxiety or worries
- Mood or behavior concerns
- Autism/developmental concerns
- School/learning difficulties
- Sleep problems
- Medication questions
- Other: \_\_\_\_\_

**In your own words, what concerns you most?**

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**When did you first notice these concerns?**

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**What are you hoping to get from this visit?**

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**SCHOOL & DAILY FUNCTIONING**

- School: \_\_\_\_\_
- Grade: \_\_\_\_\_
- Does your child have an IEP or 504 Plan?  Yes  No
- What are your child's strengths?

- 
- What are the biggest challenges at school?
- 

- Any behavior concerns at school?  Yes  No
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- How does your child do socially (friends, interactions)?
- 
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## **CURRENT SYMPTOMS**

(Check any that apply)

### **Attention / Focus**

- Trouble focusing
- Easily distracted
- Forgetful
- Disorganized
- Impulsive
- Very active/restless

### **Mood**

- Sad or down
- Irritable
- Mood swings
- Low motivation

### **Anxiety**

- Excessive worry
- Separation difficulty
- Social anxiety
- Physical symptoms (stomachaches, headaches)

**Behavior**

- Tantrums/outbursts
- Defiance
- Aggression
- Trouble with transitions

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**SLEEP (IMPORTANT)**

- What time does your child go to bed? \_\_\_\_\_
- About what time do they fall asleep? \_\_\_\_\_
- What time do they wake up? \_\_\_\_\_
- Do they nap?  Yes  No

**Sleep concerns (check any):**

- Trouble falling asleep
- Wakes during the night
- Wakes too early
- Seems tired during the day
- Snores
- Restless sleep
- Nightmares
- Does your child use screens before bed?  Yes  No
- Does your child sleep in their own bed?  Yes  No

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**MEDICATIONS**

- Current medications (name/dose if known):
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- Past medications for mood/behavior and how they worked:

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- Supplements (melatonin, vitamins, etc.):
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## MEDICAL HISTORY

### Pregnancy & Birth History

- Gestational Age at Birth: \_\_\_ weeks
- Birth Weight: \_\_\_ lbs.
- Pregnancy Complications:  None  Yes: \_\_\_\_\_
- Maternal Illness/Medications During Pregnancy: \_\_\_\_\_
- Delivery Type:  Vaginal  C-section
- NICU stay:  Yes  No
- Previous or Chronic Medical Conditions:
  - None Asthma Frequent Ear Infections Heart Problems
  - Feeding Problems Seizure Cerebral Palsy Known Genetic Disorders
  - Head Injury Meningitis Other \_\_\_\_\_
- Surgeries or hospitalizations: \_\_\_\_\_
- Allergies: \_\_\_\_\_

## DEVELOPMENTAL HISTORY

- How old do you think your child acts? \_\_\_\_\_ Years and months
  - Has your child ever lost any skills? None Language Social Motor
  - Were milestones met within expected timeframes? Yes No
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## MENTAL HEALTH HISTORY

- Has your child been diagnosed with any conditions before?  Yes  No
  - Has your child had therapy?  Yes  No
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- Any hospitalizations for mental health?  Yes  No
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### **FAMILY HISTORY**

Does anyone in the family have:

- ADHD
  - Anxiety
  - Depression
  - Autism
  - Bipolar disorder
  - Substance use concerns
- 

### **HOME & LIFESTYLE**

- Any major stressors or recent changes?
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- Activities/interests your child enjoys:
- 

### **SAFETY**

- Do you have any safety concerns about your child?  Yes  No
  - Any thoughts of self-harm or harming others?  Yes  No
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### **TOP 3 PRIORITIES**

1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
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### **ANYTHING ELSE YOU'D LIKE US TO KNOW**