Erin Jacobson, ARNP
12 Bellwether Way STE 223, Bellingham WA 98225
Ph. (360)707-7608 FAX (360)707-7648 kidspsychiatry.com

Child & Adolescent Intake Information

Patient Name:_____Preferred Name:_____

DOB: _____Gender:_____Gender Orientation:_____

Name of Person Completing this Form and your Relationship to the Child: _____

REASONS FOR THE EVALUATION

Did anyone suggest your child be seen by a mental health professional & why? _____

Briefly describe the primary reason for the evaluation? _____

_____

What other concerns do you have about your child's behavior/mood/relationships/learning? Please indicate if new concern within last month and mark with "**N**"" or long-term issue and mark with **"L":**

_Hyperactivity
_Distractibility
_Impulsivity
_Sadness/depression
_Hopelessness
_Thoughts of death
_Self-harm behaviors
_Crying Spells
_Loneliness
_Low self-worth
_Fatigue
_Change in appetite/sleep
_Withdrawal from people

_Anxiety/worry
_Panic attacks
_Extremely shy
_Obsessive thoughts
_Compulsive Behaviors
_Recurring, disturbing memories
_Suspicious/paranoid
_Hearing voices
_Seeing things not there
Unusual behaviors
_Irritability/anger
_Immaturity/acts younger than their age
_No/few friends

_Argues frequently
_Property destruction(home/school)
_Running away
_Toileting problems
_Fire setting/hurts animals
_School problems(acad/behavior/social)
_Sexual behaviors (not congruent with development and/or causes problems)
_Drug/alcohol problems(suspected/known)
_Computer addiction
_Legal problems (Becca Bill/court/detention)
_Lying
_Homicidal thoughts
_Peer/sibling conflict

Are your child's problems affecting any of the following?
_Handling everyday tasks _Self-esteem_ Relationships_ Recreational activities _School grades _ School attendance _Hygiene

Has your child ever had thoughts/made statements, or attempted to seriously hurt themselves, if yes please describe:_____
_____
_____

Kids Psychiatry
SPECIALIZING IN CHILDREN AND ADOLESCENTS

Erin Jacobson, ARNP
12 Bellwether Way STE 223, Bellingham WA 98225
Ph. (360)707-7608 FAX (360)707-7648 kidspsychiatry.com

Has your child ever experienced any of the following medical conditions/treatment?

_Medication reaction
_Allergies
_Asthma/breathing problems
_History of fainting or passing out
_Head injury/loss of consciousness
_Seizures
_Meningitis
_Frequent headaches
_Vision Problems/Corrective lens
_Frequent stomachaches
_Chronic Constipation
_Problems with kidneys, bladder
_Skin problems
_Hearing problems
_Involuntary motor movements
_Involuntary vocal sounds
_Substance abuse/addiction problems
_Pregnancy/Sexually transmitted disease
_Heart Murmur
_Heart arrhythmias
_Heart abnormalities
_EKG (electrocardiogram)
_Diabetes
_Early or delayed sexual development
_Other, please describe:

Family Composition

Parents are:_____Partnered_____Married_____Divorced_____Never Married_____Separated_____Single

Parent:_____

Name | Age | Biological or Step Parent

Occupation | Highest completed grade | Legal custody of child: yes or no

Parent:_____

Name | Age | Biological or Step Parent

Occupation | Highest completed grade | Legal custody of child: yes or no

Parent:_____

Name | Age | Biological or Step Parent

Occupation | Highest completed grade | Legal custody of child: yes or no

Parent:_____

Name | Age | Biological or Step Parent

Occupation | Highest completed grade | Legal custody of child: yes or no

Kids Psychiatry
SPECIALIZING IN CHILDREN AND ADOLESCENTS

Erin Jacobson, ARNP
12 Bellwether Way STE 223, Bellingham WA 98225
Ph. (360)707-7608 FAX (360)707-7648 kidspsychiatry.com

Please list the child's siblings and indicate if full or half sibling, age, and if they reside in the home:_____

_____

Are there currently any unusual stresses your family is experiencing (if yes please describe):_____

Is there any family conflict in the household where the child resides:_____

Interpersonal/Social/Cultural Information

Please describe your child's social support network (check all that apply):

_Family _Community Group _Support/Self Help Group _Teachers
_Neighbors _Religious/Spiritual Center _Coaches _Friends

Mental Health History

List current medications, dose, and any benefits, side effects: _____

_____

_____

_____

List past medications, dose and why your child no longer takes them: _____

_____

_____

_____

Name of current and past mental health providers {prescribers, therapists): _____

_____

List past and current psychiatric diagnoses and child's age when diagnosed: _____

_____

_____

What other treatments have been tried (dietary, holistic, alternative, church counseling, etc.): _____

_____

What do you think would be helpful treatment?_____

Kids Psychiatry
SPECIALIZING IN CHILDREN AND ADOLESCENTS

Erin Jacobson, ARNP
12 Bellwether Way STE 223, Bellingham WA 98225
Ph. (360)707-7608 FAX (360)707-7648 kidspsychiatry.com

Child's Medical History

Dates of most recent: _____physical exam_____dental exam _____ vision exam

If your child has ever been hospitalized for any medical reason or had any surgeries please describe:

_____

Other: Is there anything else that you want me to be aware of before we meet for our initial appointment? _____

_____