Parent/ Guardian (Child) Intake Form

Date: ___________________

Please complete the following information about your child and bring the completed form to your first appointment.

Patient's Name: _______________________________ Date of Birth: __________________

Name of parent(s) or guardian(s) who have legal custody of child:

____

Patient's Emergency Contact: ____

Phone: _____________________________ Relationship to patient: ______________________

Name all the people with who live with your child, and their relationship to him/her:

____

____

Child's School: ____

Grade/ Year: ____

Coordination of Care
Who referred you to me? ____

Do you wish for me to coordinate with your child's other providers? ☐ Yes* ☐ No

If yes, whom? ____

____

*If you would like me to share your child's health information with anyone other than his/her custodial parents/legal guardians, you will need to complete a Release of Information that authorizes me to do so.

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Chief Concerns

Please describe briefly what brings you to see me:

What are the three biggest concerns you have for your child right now?

1. ____
2. ____
3. ____

What are your goals for your child's treatment? What changes would you like to see?

Is your child bothered by problems with sleep? ☐ Yes ☐ No

Please describe: ____

Is your child bothered by hearing or seeing things, or by voices? ☐ Yes ☐ No

Please describe: ____

Does your child have difficulty with focusing on tasks or finishing things? ☐ Yes ☐ No

Please describe: ____

Psychiatric History

Is/ was your child receiving any type of psychotherapy or counseling? ☐ Yes ☐ No

If yes, by whom? ______________________ When? ______________________

Does your child have a history of mental health problems or hospitalizations? ☐ Yes ☐ No

If so, please complete the following:

Diagnosis	Dates Treated	By Whom

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Check if your child has a history of

- ☐ Anemia
- ☐ Attention problems
- ☐ Depression
- ☐ Digestive problems
- ☐ Heart problems
- ☐ Psychosis
- ☐ Speech problems
- ☐ Anxiety
- ☐ Bipolar
- ☐ Dental problems
- ☐ Ear infections
- ☐ Head trauma
- ☐ Seizures
- ☐ Stomach problems
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Feeding problems
- ☐ Panic Attacks
- ☐ Strep infections
- ☐ Other: ____________________

Medications taken previously (if any): ☐ My child has never taken medication

Please check the box for each medication your child has tried in the past. Next to the name of the medication, please write the dose they were prescribed and for how long they tried it.

- ☐ Prozac (fluoxetine)
- ☐ Zoloft (sertraline)
- ☐ Luvox (fluvoxamine)
- ☐ Paxil (paroxetine)
- ☐ Celexa (citalopram)
- ☐ Lexapro (escitalopram)
- ☐ Effexor (venlafexine)
- ☐ Pristiq (desvenlafexine)
- ☐ Cymbalta (duloxetine)
- ☐ Wellbutrin (bupropion)
- ☐ Desyrel (trazodone)
- ☐ Remeron (mirtazapine)
- ☐ Tegretol (carbamazepine)
- ☐ Lithium
- ☐ Depakote (valproate)
- ☐ Lamictal (Lamotrigine)
- ☐ Topamax (topiramate)
- ☐ Seroquel (quetiapine)
- ☐ Risperdal (risperidone)
- ☐ Zyprexa (olanzapine)
- ☐ Geodon (ziprasidone)
- ☐ Abilify (aripiprazole)
- ☐ Tenex (guanfacine)
- ☐ Vistaril (hydroxyzine)
- ☐ Xanax (alprazolam)
- ☐ Ativan (lorazepam)
- ☐ Restoril (temazepam)
- ☐ Klonopin (clonazepam)
- ☐ Valium (diazepam)
- ☐ Ambien (zolpidem)
- ☐ Buspar (buspirone)
- ☐ Adderall (amphetamine)
- ☐ Concerta (methylphenidate)
- ☐ Ritalin (methylphenidate)
- ☐ Strattera (atomoxetine)
- ☐ Vyvanse (lisdexamphetamine)
- ☐ Focalin (dexmethylphenidate)
- ☐ Daytrana patch (methylphenidate patch)
- ☐ Tenex (guanfacine)
- ☐ Intuniv (guanfacine ER)
- ☐ Clonidine
- ☐ Neurontin (gabapentin)
- ☐ Emsam (selegiline patch)
- ☐ Other medications:

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Medical Information

Allergies: ____

Current prescription medications:

Medicine Dosage Frequency Prescribed by

____

____

____

____

Current over the counter medications, herbal remedies, and nutritional supplements:

____

Current medical problems:____

____

Past medical problems, hospitalizations, and surgeries:

____

____

Do you have any other concerns about your child's health that you'd like to discuss with me during our appointment? ☐ Yes ☐ No

Primary care provider: ____

Substance Use:

Has your child ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, for which substances? ____

If yes, where were they treated and when? ____________________________________

To your knowledge, has your child ever tried alcohol or other drugs? ☐ Yes ☐ No

Legal History:

Has your child ever been arrested? ☐ Yes ☐ No

If yes, please explain: ____

Does your child have any pending legal problems? ☐ Yes ☐ No

If yes, please explain: ____

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Developmental History:

Was your child adopted? ☐ Yes ☐ No   If yes, at what age? __________________________

When your child was born, were there any medical concerns during labor, delivery, or immediately after his/her birth? ☐ Yes ☐ No ☐ Not sure
Please describe: ____

Developmental milestones (sitting up, walking, talking, toilet training, etc.) were:
☐ On time ☐ Delayed ☐ Earlier than other children ☐ Not sure

How many brothers or sisters? How old are they? _______________________________________

____

Mother's occupation? ______________________ Father's occupation? ______________________

Has your child experienced parental divorce? ☐ Yes ☐ No

If so, how old was your child? ________________

If so, with whom does your child live?____

Describe your child's relationship with you: ____

____

Describe your child's relationship with their other parent (s): ______________________________

____

What, if any, are your child's responsibilities at home? __________________________________

Trauma History

To your knowledge, was your child ever physically, verbally, or sexually abused? _____________

If so, please briefly describe: ____

Has your child ever experienced the loss or death of a close loved one? ☐ Yes ☐ No

If so, please briefly describe circumstances: ____

Spirituality

Does your family belong to a particular religion or spiritual group: ☐ Yes ☐ No

If yes, what is the level of your family's involvement? ___________________________________

If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is particularly important to you? ☐ Yes ☐ No

Please explain: ____

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Educational History:

What school does your child attend? ____

How are his/her grades?____

Does your child have any identified learning disabilities?______________________________

If your child has had any specialized academic testing, please describe: ___________________

____

How does your child do socially at school? ____

____

What are your child's best subjects? ____

Worst subjects? ____

What do your child's teachers say about him/her? ___________________________________

____

Recreation

What kind(s) of exercise does your child get? _______________________________________

In what after school activities does your child participate? ____________________________

____

Does your child play video games? ☐ Yes ☐ No

If so, which ones?____

How many hours per day? ________________ Hours per week? ____________________

Does your child watch television? ☐ Yes ☐ No

How many hours per day? ________________ Hours per week? ____________________

Does your child have a television or computer in their bedroom? ☐ Yes ☐ No

Does your child have their own cell phone? ☐ Yes ☐ No

How often does your child visit with his or her friends? _____________________________

What do you think about your child's group of friends? ______________________________

____

What are your child's personal strengths? ____

____

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Other Concerns

Please tell me anything other information that you believe may improve my ability to provide effective care for your child.

Your child's comfort is very important, and some material is better discussed with them not present. Is there anything in the above information that you do not want your child to know?

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