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CHILD AND ADOLESCENT PSYCHIATRY
INTAKE QUESTIONNAIRE

This questionnaire is meant to collect important background information used in an intake interview with an individual under 18 y.o. Please complete this form as accurately and thoroughly as possible.

Patient Information:

Patient's Full Name: _____
Please *circle* the preferred first name above. If not listed, please indicate here: _____
Age: _____ Gender: M F Date of Birth: _____ Social Security Number: _____
Preferred Mailing Address: _____

Parent Information:

Parent's Name: _____
Relation to Patient: ___ Biological Parent ___ Step-Parent ___ Adoptive Parent
(Check all that apply) ___ Legal Guardian ___ Other: _____
Parent's Contact Numbers: H _____ W _____ C _____
Parent's Title and/or Occupation: _____

Parent's Name: _____
Relation to Patient: ___ Biological Parent ___ Step-Parent ___ Adoptive Parent
(Check all that apply) ___ Legal Guardian ___ Other: _____
Parent's Contact Numbers: H _____ W _____ C _____
Parent's Title and/or Occupation: _____

Parent's Name: _____
Relation to Patient: ___ Biological Parent ___ Step-Parent ___ Adoptive Parent
(Check all that apply) ___ Legal Guardian ___ Other: _____
Parent's Contact Numbers: H _____ W _____ C _____
Parent's Title and/or Occupation: _____

Parent's Name: _____
Relation to Patient: ___ Biological Parent ___ Step-Parent ___ Adoptive Parent
(Check all that apply) ___ Legal Guardian ___ Other: _____
Parent's Contact Numbers: H _____ W _____ C _____
Parent's Title and/or Occupation: _____

Emergency Contact:

In an emergency, may we contact anyone besides a parent? Y N Contact's Relation: _____
Emer. Contact's Name: _____
Emer. Contact's Numbers: H _____ W _____ C _____

Referral Information:

Did anyone refer this individual to us? Y N If so, who? _____
Who is this individual's physician for routine care? _____
Please describe the reasons you are seeking an evaluation. _____

Review of Symptoms:

Please indicate any of the following symptoms that have been obvious and problematic.

Behaviors:

- Acts strangely.
- Attempts weight loss.
- Seeks attention.
- Argues with adults.
- Avoids homework.
- Blames others.
- Bullies others.
- Doesn't accept affection.
- Doesn't listen to others.
- Doesn't offer affection.
- Doesn't stay on task.
- Doesn't stay seated.
- Doesn't wait turn.
- Checks (as a ritual).
- Counts (as a ritual).
- Exercises excessively.
- Fidgets a lot.
- Hoards objects.
- Initiates fights.
- Insists upon rituals.
- Interrupts others.
- Lacks conscience.
- Lacks follow through.
- Lacks imaginative play.
- Lies.
- Loses items for class.
- Misses curfews.
- Runs away.
- Sets fires.
- Shows inflexibility.
- Shows narrow interests.
- Shows perfectionism.
- Startles easily.
- Steals.
- Takes risks.
- Talks excessively.
- Talks too fast.
- Tortures animals.
- Vandalizes.
- Washes hands repeatedly.

Fears:

- Fears abandonment.
- Fears being away from family.
- Fears crowds.
- Fears dying.
- Fears embarrassment.
- Fears gaining weight.
- Fears losing loved ones.

Feelings:

- Feels agitated.
- Feels angry.
- Feels anxious.
- Feels cocky.
- Feels depressed.
- Feels indecisive.
- Feels invincible.
- Feels helpless.
- Feels hopeless.
- Feels lack of self-worth.
- Feels moody.
- Feels unstable.

Interpersonal:

- Doesn't reciprocate emotions.
- Has poor social skills.
- Is easily influenced.
- Lacks any concern for praise.
- Lacks peer relationships.
- Shows poor eye contact.
- Shows unusual speech.

Thoughts:

- Forgets things.
- Has delusions
- Has disorganized thoughts.
- Has intrusive thoughts.
- Has paranoia.
- Has rapid thoughts.
- Hears voices not there.
- Lacks focus.
- Lacks motivation.
- Lacks organization.
- Obsesses over symmetry.
- Sees things not there.
- Thinks of death.
- Worries about health.

Physical Symptoms:

- Feels chills or hot flashes.
- Feels muscle tension.
- Feels nauseated.
- Feels restless.
- Feels sleepy in daytime.
- Feels too energetic.
- Feels too tired.
- Gained appetite.
- Gained weight.
- Lost appetite.
- Lost weight.
- Needs little sleep.
- Sleeps too little.
- Sleeps too much.
- Sweats.
- Trembles.

Past Psychiatric History:

Have this individual ever met with a mental health professional in the past? Y N If so, please list the names of any treatment providers, their specialty (e.g. Psychologist), and time period for treatment: _____

Has this individual ever been admitted to a mental health facility? Y N If so, please list each location, time period for admission, and reason for admission. _____

Has this individual ever tried to harm himself or herself? Y N If so, please describe the incident, stressors present during the incident, and when the incident occurred: _____

Has this individual ever thought of harming himself or herself? Y N If so, please describe when these thoughts occurred and any stressors which may have been related: _____

Past Medical History:

Please indicate if this individual has had problems with the following medical conditions.

- Asthma Glaucoma Heart Problems Seizures
- Cancer Head Aches Kidney Problems Thyroid Problems
- Diabetes Head Trauma Liver Problems

Please describe the severity and time course for any of these conditions and describe any other medical conditions which were not listed above: _____

Has this individual had hearing checked? Y N If so, when was the last time? _____

Has this individual had vision checked? Y N If so, when was the last time? _____

Has this individual had ear tubes placed? Y N If so, when were they placed and have they been removed? _____

Past Surgical History:

Please describe any major surgeries this individual has underwent to include the reason for surgery and the approximate date of surgery. _____

All Current Medications:

Name of Medication	Dosage	Dates of Treatment	Effect(s) from Medication

(Please continue on page margin if list exceeds the table.)

Mental Health Medications Previously Tried:

Name of Medication	Dosage	Dates of Treatment	Effect(s) from Medication

(Please continue on page margin if list exceeds the table.)

Allergies to Medication(s):

Does this individual have any known allergies to any medications? Y N If yes, then please list all medications that have caused an allergic reaction and describe the reactions to each one:

Family Psychiatric History:

Please indicate if this individual has family members who have experienced the following.

- Anxiety Attempted Suicide Completed Suicide Self-Mutilation
 Bipolar Disorder Depression Panic Attacks Substance Abuse
 Attention-Deficits Psychosis

Please describe the severity and time course for any of these conditions and describe any other psychiatric conditions that run in the family. _____

Developmental History:

Did this individual's mother use any alcohol during pregnancy? Y N If so, please describe.

Did this individual's mother use any illicit drugs during pregnancy? Y N If so, please describe.

Did this individual's mother use any tobacco during pregnancy? Y N If so, please describe.

Did this individual's mother use medications during pregnancy? Y N If so, please describe.

Were there any complications during the pregnancy, at birth, or shortly after birth? Y N

If so, please describe. _____

Was this individual born early, late, or on time? _____ Weight at birth? _____

Was this individual born via natural delivery or C-Section? _____

How old was this individual when first walking? _____

How old was this individual when first talking? _____

How old was this individual when first potty trained? _____

Social History:

Please describe where this individual was born and raised. Please include approximate time periods for each location. Please also describe who was raising this individual during various time periods. _____

Is this individual currently in school? Y N If so, which school and what grade level? _____

Has this individual repeated or skipped any grades? Y N If so, please describe. _____

Has this individual had disciplinary problems at school? Y N If so, please describe. _____

Has this individual or his/her siblings ever been the focus of an investigation by the Department of Family and Children's Services (DFCS)? Y N If so, please describe. _____

Has this individual ever been sexually abused? Y N If so, by whom and when? _____

Has this individual ever been physically abused? Y N If so, by whom and when? _____

Has this individual ever been emotionally abused? Y N If so, by whom and when? _____

Has this individual ever had basic needs neglected? Y N If so, by whom and when? _____

Habits:

Has this individual used illicit substances? Y N If so, please list all substances tried, maximum daily use, and approximate time period each substance was used. Please also list any legal difficulties faced due to illicit substance use: _____

Has this individual used alcohol? Y N If so, please list the age at first drink, maximum daily use, and approximate time period for use. Please also list any legal difficulties caused by use of alcohol. _____

Has this individual used tobacco? Y N If so, please list the age of first use, maximum daily use, and time period for use: _____

I have filled out the preceding information as accurately as possible. Since the information concerns a minor, I understand that I can only sign this form if I am an actual guardian.

Guardian

Printed Name of Guardian

Date Signed