Pediatric Psychiatric Intake Form – Patient/Parent

GENERAL INFORMATION

Patient Name: _____ Date of Birth: _____

Person completing form: _____ Relation to patient: _____

PLEASE DESCRIBE THE REASON FOR VISIT AND/OR CURRENT CONCERNS:

_____

_____

_____

RISK ASSESSMENT

Has your child ever attempted suicide?	☐ Yes	☐ No
Has your child ever harmed themselves by cutting, burning, etc.?	☐ Yes	☐ No

Has your child recently engaged in risk-taking behavior? *(Check all that apply)*

☐ Alcohol/drug use ☐ Gang involvement ☐ Unprotected sex ☐ Drug dealing ☐ Shoplifting

☐ Trading sex for money, drugs or possessions ☐ Reckless driving ☐ Carrying/using a weapon

☐ Other: _____

Do you feel that you live in a safe place?	☐ Yes	☐ No
Are there guns in your home?	☐ Yes	☐ No
If yes, are the guns locked up?	☐ Yes	☐ No
Has your child ever witnessed violence in the home?	☐ Yes	☐ No

LEGAL INVOLVEMENT

Has your child ever been on probation?	☐ Yes	☐ No
Has your child ever received child protective services (CPS)?	☐ Yes	☐ No
Has your child had any other involvement with the legal system?	☐ Yes	☐ No

If yes to any of the above, please explain:

_____

MENTAL HEALTH HISTORY ***Please check all current and previous mental health care***

Provide details (location, dates, provider's name, etc.)

☐ Inpatient Hospitalization Details: _____

☐ Partial Hospitalization (PHP) Details: _____

☐ Intensive Outpatient (IOP) Details: _____

☐ Residential Treatment (IRTS) Details: _____

☐ Psychiatric Care Details: _____

☐ Therapy Details: _____

☐ Substance Abuse Treatment Details: _____

☐ Case Management Details: _____

☐ In-home Skills/Family Therapy Details: _____

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□ Other: Details: _____

ALL CURRENT *AND* PAST MEDICATIONS TRIED

Antidepressants
□ Prozac (fluoxetine)
□ Zoloft (sertraline)
□ Lexapro (escitalopram)
□ Celexa (citalopram)
□ Luvox (fluvoxamine)
□ Paxil (paroxetine)
□ Wellbutrin (bupropion)
□ Effexor (venlafaxine)
□ Pristiq (desvenlafaxine)
□ Cymbalta (duloxetine)
□ Viibryd (vilazodone)
□ Fetzima (levomilnacipran)
□ Trintellix (vortioxetine)
□ Elavil (amitriptyline)
□ Pamelor (nortriptyline)
□ Tofranil (imipramine)
□ Norpramin (desipramine)
□ Anafranil (clomipramine)
□ Emsam (selegiline)

Anti-Anxiety / Anti-Hypertensives
□ Catapres (clonidine)
□ Kapvay (clonidine ER)
□ Tenex (guanfacine)
□ Intuniv (guanfacine ER)
□ Buspar (buspirone)
□ Vistaril (hydroxyzine pamoate)
□ Atarax (hydroxyzine hcl)
□ Inderal (propranolol)
□ Tenormin (atenolol)

Benzodiazepines
□ Xanax (alprazolam)
□ Ativan (lorazepam)
□ Klonopin (clonazepam)
□ Valium (diazepam)
□ Restoril (temazepam)
□ Librium (chlordiazepoxide)

Stimulants
□ Adderall (dextroamphetamine/amphetamine)
□ Vyvanse (lisdexamfetamine)
□ Dexedrine (dextroamphetamine)
□ Adzenys (amphetamine ODT or liquid)
□ Concerta (methylphenidate ER)
□ Ritalin LA (methylphenidate LA)
□ Metadate (methylphenidate CD)
□ Daytrana (methylphenidate patch)
□ Quillivant (methylphenidate chew or liquid)
□ Focalin (dexmethylphenidate)
□ Strattera (atomoxetine)
□ Provigil (modafinil)
□ Nuvigil (armodafinil)

Mood Stabilizers
□ Lamictal (lamotrigine)
□ Trileptal (oxcarbazepine)
□ Lithobid/Eskalith (lithium)
□ Depakote (valproic acid/divalproex)
□ Tegretol (carbamazepine)
□ Topamax (topiramate)
□ Neurontin (gabapentin)

Antipsychotics / Neuroleptics
□ Risperdal (risperidone)
□ Abilify (aripiprazole)
□ Rexulti (brexpiprazole)
□ Seroquel (quetiapine)
□ Zyprexa (olanzapine)
□ Invega (paliperidone)
□ Latuda (lurasidone)
□ Geodon (ziprasidone)
□ Vraylar (cariprazine)
□ Saphris (asenapine)
□ Haldol (haloperidol)
□ Clozaril (clozapine)
□ Thorazine (chlorpromazine)
□ Fanapt (iloperidone)

Sleep Aids / Sedatives
□ melatonin
□ Unisom (doxylamine)
□ Benadryl (diphenhydramine)
□ Desyrel (trazodone)

□ Remeron (mirtazapine)
□ Ambien (zolpidem)
□ Lunesta (eszopiclone)
□ Sonata (zaleplon)
□ Silenor (doxepin)
□ Rozerem (ramelteon)

YOUR CHILD'S DEVELOPMENT

Is your child adopted? □ Yes □ No If yes, at what age? _____

How long was the pregnancy? _____ Weeks □ Unknown

Concerns or complications that occurred during pregnancy (*check all that apply*):

□ No (or poor) prenatal care
□ Preeclampsia
□ Gestational Diabetes
□ Unknown
□ Preterm labor
□ Serious infection or illness
□ Significant stress or trauma
□ Other _____
□ Tobacco use
□ Alcohol use
□ Drug use

-How was your child delivered?	□ Vaginal	□ Cesarean	□ Unknown
-Was your child's delivery induced?	□ Yes	□ No	□ Unknown
-Was your child's delivery an emergency?	□ Yes	□ No	□ Unknown
-Did your child come home within 2 days of delivery?	□ Yes	□ No	□ Unknown
-Were there any complications during labor or the delivery of your child?	□ Yes	□ No	□ Unknown

If yes to any of the above, please explain:

_____

_____

Concerns during your child's development (*check all that apply*):

□ Social skills/interacting with others
□ Play
□ Activity level
□ Gross motor skills (running, moving, crawling)
□ Fine motor skills (eating, writing, buttoning a shirt)
□ Calming
□ Tantrums
□ Language
□ Speech
□ Vision
□ Hearing

Childhood developmental delays (*check all that apply*):

□ Speech
□ Sitting, crawling, or walking
□ Toilet training
□ Sleeping through the night

□ Other: _____

FAMILY MENTAL HEALTH HISTORY

□ Suicide attempt	Who:_____
□ Death by suicide	Who:_____
□ Schizophrenia	Who:_____
□ Bipolar disorder	Who:_____
□ Depression	Who:_____
□ Anxiety	Who:_____
□ ADHD	Who:_____
□ Autism Spectrum Disorder	Who:_____
□ OCD	Who:_____
□ Personality Disorder	Who: _____
□ Eating Disorder	Who: _____
□ Alcoholism	Who:_____
□ Drug addiction	Who:_____

□ Other: _____

SOCIAL HISTORY

Who does your child live with? *(Check all that apply)*

□ Father
□ Mother
□ Step parent(s)
□ Sibling(s)
□ Grandparent(s)
□ Foster care
□ Other: _____

Describe your child's biological parents' current relationship *(Check all that apply)*

□ Never married, living together
□ Never married, living apart
□ Married
□ Separated
□ Divorced
□ Biological mother remarried
□ Biological father remarried
□ Widowed
□ Other: _____

Please describe any court-ordered custody arrangements regarding your child:

_____

_____

SUPPORT SYSTEM

Who is most supportive to your child? *(Check all that apply)*

□ Father
□ Mother
□ Step parent(s)
□ Sibling(s)
□ Grandparent(s)
□ Teacher(s)
□ Friend(s)
□ Pastor/Spiritual Leader
□ Other: _____

EDUCATION HISTORY

Current School: _____ Grade: _____

Has your child experienced any difficulties with the following? (*check all that apply*)
□ Reading
□ Writing
□ Math
□ Other: _____

-Does your child have an Individualized Education Plan (IEP)? □ Yes □ No
-Does your child have a 504 plan? □ Yes □ No

EMPLOYMENT

-What is your child's employment status? (*Check one*)

□ Employed full-time
□ Employed part-time
□ Not employed and NOT seeking employment
□ Not employed and seeking employment
If employed, where does your child work? _____

-What is your employment status? (*Check one*)

□ Employed full-time
□ Employed part-time
□ Not employed and NOT seeking employment
□ Not employed and seeking employment
If employed, what is your occupation? _____

-What is the employment status of your child's other parent/guardian? (*Check one*)

□ Employed full-time
□ Employed part-time
□ Not employed and NOT seeking employment
□ Not employed and seeking employment
If employed, what is his/her occupation? _____

STRENGTHS & INTERESTS

List three of your child's strengths, special gifts and/or talents:

1. _____
2. _____
3. _____

List three activities or hobbies that your child enjoys:

1. _____
2. _____
3. _____

MEDICAL CONCERNS

Head
- ☐ Concussion
- ☐ Head injury
- ☐ Headaches
- ☐ Migraines
- ☐ Traumatic brain injury
- ☐ Other: _____

Eyes
- ☐ Needs glasses/contacts
- ☐ Eye pain
- ☐ Double vision
- ☐ Decreased vision
- ☐ Other: _____

Ears, Nose, Throat
- ☐ Difficulty hearing
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Difficulty swallowing
- ☐ Pain
- ☐ Other: _____

Cardiovascular
- ☐ Murmur
- ☐ Chest pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Shortness of breath
- ☐ Difficulty lying flat
- ☐ Swelling ankles
- ☐ Other: _____

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Black or bloody bowel movement
- ☐ Other: _____

Genitourinary
- ☐ Increased urinary frequency
- ☐ Bedwetting
- ☐ Blood in urine
- ☐ Pain/discomfort
- ☐ Abnormal discharge
- ☐ Bladder leakage
- ☐ Menstrual issues
- ☐ Other: _____

Musculoskeletal
- ☐ Joint pain/swelling
- ☐ Stiffness
- ☐ Muscle pain
- ☐ Back pain
- ☐ Other:_____

Neurological
- ☐ Loss of strength
- ☐ Numbness
- ☐ Headaches
- ☐ Tremors
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tourette's syndrome
- ☐ Other: _____

Constitutional
- ☐ Weight gain
- ☐ Sleep difficulties
- ☐ Poor appetite
- ☐ Weight loss
- ☐ Fatigue
- ☐ Fever
- ☐ Other: _____

Sensory Concerns
- ☐ Sound/noise
- ☐ Touch/tactile
- ☐ Oral/textures
- ☐ Clothing/tactile
- ☐ Scent/smell
- ☐ Other: _____

Endocrine
- ☐ Unexplained wght loss
- ☐ Unexplained wght gain
- ☐ Hot/cold intolerance
- ☐ Diabetes
- ☐ Thyroid issues
- ☐ Other: _____

Respiratory

□ Cough
□ Pain
□ Shortness of breath
□ Use of inhaler
□ Use of oxygen
□ Other: _____

Skin

□ Hair loss
□ Rash/hives
□ Lesions/sores
□ Itching
□ Easy bruising

□ Other: _____