

Child and Adolescent Intake Information

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Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Gender Male Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Racial/Ethnic Identification \_\_\_\_\_

Legal Guardian name \_\_\_\_\_ Relation to Child \_\_\_\_\_

Home Address \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_

\_\_\_\_\_

Person Completing this form? \_\_\_\_\_ Relation to Child \_\_\_\_\_

Who referred you here? \_\_\_\_\_

Primary care physician? \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Briefly describe your chief concern at this time: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long has this been a problem or concern for you \_\_\_\_\_

When did you first notice the problem? \_\_\_\_\_

Has your child previously been evaluated or received treatment for this problem? Yes No

If yes, when and with whom? \_\_\_\_\_

Results of that evaluation and/or treatment? \_\_\_\_\_

Current Medications (including prescribed drugs, herbal, vitamin, homeopathic, naturopathic and over the counter)

Name	Dose	Last Given
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Medications tried for this problem

Name	Name
1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	_____

Home Information

Biological Mother's Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Highest grade/degree completed \_\_\_\_\_

Biological Father's Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Highest grade/degree completed \_\_\_\_\_

Step Father's Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Highest grade/degree completed \_\_\_\_\_

Step Mother's Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Highest grade/degree completed \_\_\_\_\_

If parents are separated or divorced, how old was this child when separation occurred? \_\_\_\_\_

What are the current custody/visitation arrangements? \_\_\_\_\_

Is the non-custodial parent aware of this consultation? Yes No

Please list all people living in the primary household of the child  
Name Relationship to patient Age

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all family members (including step family) who live outside of primary household  
Name Relationship to patient Age

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other important information about home situation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Primary language spoken in the home: \_\_\_\_\_

Other languages spoken in the home: \_\_\_\_\_

## Developmental History

Is this child adopted?      Yes      No

Duration of pregnancy (weeks or months) \_\_\_\_\_ Planned Pregnancy    Yes    No

During the pregnancy, did the mother:

Suffer from disease/illness

Undergo surgery

Take prescribed medication

Take herbal, naturopathic, homeopathic

Have x-rays

Smoke

Drink alcohol/beer/wine

Amount per week \_\_\_\_\_

Use recreational drugs

Drugs used \_\_\_\_\_

Suffer from an accident

Complications of Pregnancy:

Excessive vomiting

Excessive staining/blood loss

Threatened miscarriage

Premature labor

Infections

Toxemia

Diabetes

High Blood Pressure

Poor nutrition

Amniocentesis

Loss of Consciousness in mother

### Delivery

Type of Delivery      Vaginal      Scheduled C-section      Emergency C-section

Duration of Labor \_\_\_\_\_ hours      Birth Weight \_\_\_\_\_ Length \_\_\_\_\_

Type of Labor      Spontaneous      Induced      Were forceps used?      Yes      No

Complications

None

Cord around neck

Problems with placenta

Hemorrhage

Meconium staining/aspiration

Delay in breathing

Injury to infant

Intraventricular hemorrhage

Need respirator/resuscitation

Other \_\_\_\_\_

Was your baby in the NICU?      No      Yes      If yes, for how long? \_\_\_\_\_

### Post Natal Complications

None

Addiction

Anemia

Diarrhea

Jaundice

Infection

Seizures

Vomiting

Other

### Infancy and Toddler Period

As a baby, the child was

Active       Difficult       Shy       Hard to please  
 Cranky       Easy       Sleepy       Lazy or slow moving  
 Calm       Happy       Social       Persistent

Were there any special problems in the development of the child during the first years?

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Were any of the following present in the first five years of life?

- Colic
- Exceptional Clinginess or difficulty separating from caregivers
- Difficulty getting to sleep
- Slow or unable to adapt to changes in routines
- Difficulty staying asleep
- Excessively high or low activity level (Circle one)
- Difficulty waking
- Not calmed by being held or stroked
- Feeding Problems
- Excessive number of accidents/clumsiness
- Frequent Headbanging
- Problems adjusting to new people or situation
- Excessive restlessness
- Poor eye contact
- Did not enjoy cuddling
- Evidence of allergies to medications or immunizations
- Constantly into everything
- Excessive Temper tantrums

Developmental milestones

(Please circle appropriate range)

Behavior

Compared to other children

Sat up unassisted	Early	6-9 mos	Late
Walked alone	Early	9-15 mos	Late
Spoke first word	Early	9-14 mos	Late
Several words together	Early	14-18 mos	Late
Daytime bladder control	Early	24-48 mos	Late
Daytime bowel control	Early	24-36 mos	Late
Dry at night	Early	36-48 mos	Late
Fed self with fork	Early	18-24 mos	Late
Rode Tricycle	Early	30-42 mos	Late

What do you regard as your child's greatest strengths at this time?

What are your child's greatest weaknesses at this time?



**MEDICAL HISTORY**

Please place a check by any illness or condition that your child has or has had, and note the child age at that time.

- |                          |                               |                          |  |
|--------------------------|-------------------------------|--------------------------|--|
| <input type="checkbox"/> | AIDS or HIV positive          | <input type="checkbox"/> | Headaches                                    |
| <input type="checkbox"/> | Allergies (what?) _____       | <input type="checkbox"/> | Heart Problems/disease                       |
| <input type="checkbox"/> | _____                         | <input type="checkbox"/> | Heavy Metal Poisoning (e.g., Lead)           |
| <input type="checkbox"/> | _____                         | <input type="checkbox"/> | Hepatitis ABC (circle one)                   |
| <input type="checkbox"/> | Aneurysm                      | <input type="checkbox"/> | Herpes or other sexually transmitted disease |
| <input type="checkbox"/> | Anoxia/stopped breathing      | <input type="checkbox"/> | High blood pressure                          |
| <input type="checkbox"/> | Arthritis                     | <input type="checkbox"/> | Jaundice Neonatal                            |
| <input type="checkbox"/> | Asthma                        | <input type="checkbox"/> | Jaundice other                               |
| <input type="checkbox"/> | Gross motor problems (Ataxia) | <input type="checkbox"/> | Leukemia                                     |
| <input type="checkbox"/> | Auto accident                 | <input type="checkbox"/> | Malnutrition                                 |
| <input type="checkbox"/> | Bleeding disorders            | <input type="checkbox"/> | Meningitis                                   |
| <input type="checkbox"/> | Bone or joint disease         | <input type="checkbox"/> | Muscular disease                             |
| <input type="checkbox"/> | Brain tumor                   | <input type="checkbox"/> | Pain problems                                |
| <input type="checkbox"/> | Broken bones                  | <input type="checkbox"/> | Paralysis                                    |
| <input type="checkbox"/> | Cancer                        | <input type="checkbox"/> | Physical abuse                               |
| <input type="checkbox"/> | Comaloss of consciousness     | <input type="checkbox"/> | Pneumonia                                    |
| <input type="checkbox"/> | Concussion                    | <input type="checkbox"/> | Poisoning (what?) _____                      |
| <input type="checkbox"/> | Diabetes                      | <input type="checkbox"/> | Rheumatic fever                              |
| <input type="checkbox"/> | Fine motor problems (Apraxia) | <input type="checkbox"/> | Scarlet Fever                                |
| <input type="checkbox"/> | Ear infections                | <input type="checkbox"/> | Loss of sensation                            |
| <input type="checkbox"/> | PE tubes                      | <input type="checkbox"/> | Sexual abuse                                 |
| <input type="checkbox"/> | Hives/Eczema                  | <input type="checkbox"/> | Sickle cell disease                          |
| <input type="checkbox"/> | Encephalitis                  | <input type="checkbox"/> | Speech/Language problems                     |
| <input type="checkbox"/> | Epilepsy, seizures, fits      | <input type="checkbox"/> | Stroke                                       |
| <input type="checkbox"/> | Eye problems                  | <input type="checkbox"/> | Suicidal thoughts/attempts                   |
| <input type="checkbox"/> | Fainting spells               | <input type="checkbox"/> | Sunstroke/heat exhaustion                    |
| <input type="checkbox"/> | Fetal Alcohol syndrome        | <input type="checkbox"/> | Thyroid disorder/problems                    |
| <input type="checkbox"/> | Genetic disorder              | <input type="checkbox"/> | Tumor (not brain tumor)                      |
| <input type="checkbox"/> | Head Injury                   | <input type="checkbox"/> | Vision problems                              |

Other chronic or acute medical problems, chronic or serious illness, or operations your child has had and child's age:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been seen in an Emergency Room? Why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized? Why? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has your child ever had any of the following evaluations? If yes, indicate age

- |                          |        |                          |                 |
|--------------------------|--------|--------------------------|-----------------|
| <input type="checkbox"/> | EEG    | <input type="checkbox"/> | MRI scan        |
| <input type="checkbox"/> | X-rays | <input type="checkbox"/> | Vision testing  |
| <input type="checkbox"/> | CTscan | <input type="checkbox"/> | Hearing testing |

**FAMILY MEDICAL HISTORY**

Please place a check by any illness, condition or problem experienced by a blood relative and note the relationship of that person to the child.

Disorder	Relationship
Alcoholism	
Anger management problems	
Antisocial (Criminal) behavior	
Anxiety	
Asthma	
Attention Deficit Hyperactivity Disorder	
Autism & related disorders	
Bipolar disorder	
Cancer	
Chronic Pain problems	
Dementia	
Depression	
Diabetes	
Drug problems	
Headaches	
Heart disease; Heart attack	
Hyperactivity	
High Blood Pressure	
Learning Problems	
Stroke	
COPD/Emphysema	
Mental Retardation	
Movement disorders	
Emotional problems	
Physical Abuse	
Schizophrenia	
Seizures, epilepsy or convulsions	
sexual abuse	
Sleep problems	
Suicide or suicide attempt	
Other?	

Where were you living August 2005? (City/State) \_\_\_\_\_

Did you sustain damage in Hurricane Katrina? If yes, please note: \_\_\_\_\_

how many schools has this child attended since August 2005? \_\_\_\_\_

In how many places has this child resided since August 2005? \_\_\_\_\_

What has been the most significant change/stressor for this child since August 2005?  
\_\_\_\_\_

What has been the most significant resource/strength for this child since August 2005?  
\_\_\_\_\_