

Child and Adolescent Intake Information

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)

Dose

Last Given

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

Prior Medications tried for this problem

Name Name

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_

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
- Jaundice
- Addiction
- Infection
- Anemia
- Seizures
- Diarrhea
- Vomiting
- Other \_\_\_\_\_

**Infancy and Toddler Period**

As a baby, the child was

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

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

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

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

Developmental milestones Behavior  
 (Please circle appropriate range) 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?

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

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**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? \_\_\_\_\_