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Independent Practitioner Serving East. Snohomish and King Counties

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Child and Adolescent Intake Information and Medical History

Your assistance in completing this questionnaire will be helpful in planning services as I work from a systems perspective. If there is any information you would prefer not to share, please let me know.

Identifying Information

Today's date: _____

Child Name: _____ Date of Birth: _____

Address: _____

City _____ State _____ Zip _____

Phone: _____ OK to leave a message for you there? Yes No

Cell Phone: _____ OK to leave a message for you there? Yes No

Primary Caregiver(s)

Please provide the name and contact information of the parent(s) with whom the child primarily resides:

Name: _____ Relationship to Child: _____

Contact Number: _____ Occupation: _____

Name: _____ Relationship to Child: _____

Contact Number: _____ Occupation: _____

Emergency Contact Information (Name & Telephone Numbers): _____

Secondary Caregiver(s)

Please provide the name and contact information of the parent with whom the child does not primarily reside (if applicable):

Name: _____ Relationship to Child: _____

Contact Number: _____ Occupation: _____

Name: _____ Relationship to Child: _____

Contact Number: _____ Occupation: _____

Name of Parent's Spouse/Partner: _____

What is the current custody arrangement with your child?(If divorced or separated)

Joint physical and legal custody Joint physical custody

Joint legal custody Sole legal custody

In the case of joint legal custody, is your child's other parent aware that you are seeking treatment for your child? Yes No

Is there a Court Order mandating treatment for your child? Yes No

Insurance Information:

Primary Insurance _____ Secondary Insurance: _____

Phone #: _____ Phone #: _____

Contract #: _____ Contract # _____

Group #: _____ Group #: _____

Subscriber: _____ Subscriber: _____

Subscriber date of birth: _____ Subscriber date of _____

Patient's relationship to subscriber: _____ Patient relationship to subscriber: _____

Reason(s) for Seeking Treatment at this time:

Please circle all that apply:

- | | | | | | | |
|--------------------|-------------------|---------------------|------------------------------|-----------------|-------------------|--------------|
| Anger | Anxiety | Lacks coping skills | Depression | Relationships | +/-Sleep disorder | |
| Aggression | Antisocial | Avoiding people | Cyber addiction | Distracted | Elevated mood | Fatigue |
| Hyperactive | Gambling | Hallucinations | Worry | Hopelessness | Impulsivity | Irritability |
| Judgment errors | Grief | Loneliness | Obsessive thoughts / rituals | PTSD | Withdrawing | |
| Memory lapses | Mood shifts | Panic attacks | Hearing voices | Family issues | Sexual behaviors | |
| Court order | Sick often | Disorganized | Nightmares | Sadness/Tearful | Low self esteem | |
| separation anxiety | frequent injuries | self harm | defiant/tantrums | expects failure | | |
| Fear/Phobias | Mental Confusion | Alcohol | Drugs | Suicide threats | Stress/tension | +/-Weight |

How long have you observed the changes in your child's emotions, behaviors, etc.?

In what areas are you noticing these changes, e.g., school, home, church, etc.?

Has anyone besides you noticed and observed these changes? Yes No

If yes, who? _____

Has anyone recommended that your child receive treatment? Yes No

If yes, who? _____

Family Dynamics

Siblings/Step-Siblings/Other Children in the Home

Name Age Gender Relationship to Child Living at Home?

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

*Feel free to use the back of this form if more room is needed.

Within the last year or so has your family experienced any major changes or stressors?

Yes No

Please indicate past and/or current, and please explain:

Past Current Financial problems: _____

Past Current Medical problems/concerns: _____

Past Current Surgery/hospitalizations: _____

Past Current Frequent moves: _____

Past Current Job changes: _____

Past Current Drinking/drug problems: _____

Past Current Arguments between parents: _____

Past Current Physical/sexual abuse: _____

Past Current Domestic violence: _____

Past Current Conflict between family members: _____

Past Current Sibling conflict: _____

Past Current Separation/divorce of parents: _____

Past Current Remarriage of parents: _____

Past Current An absent parent returning to child's life: _____

Past Current Separation from family members: _____

Past Current Legal problems: _____

Past Current Other problems: _____

Family Medical and Psychiatric History

Does any member of this child's family (parent, sibling, grandparent or other immediate family member) have a history of any medical, psychiatric, or developmental disorders?

Yes No If yes please specify below.

Neurological Disorders

| Condition | Paternal Side | Maternal Side | Sibling |
|------------------|----------------------|----------------------|----------------|
| Stroke | _____ | _____ | _____ |
| Migraines | _____ | _____ | _____ |

Mental Retardation _____
 Alzheimer's Disease _____
 Seizures _____
 Cerebral Palsy _____
 Head Trauma _____
 Other: _____

Medical Problems

| <u>Condition</u> | <u>Paternal Side</u> | <u>Maternal Side</u> | <u>Sibling</u> |
|-------------------|----------------------|----------------------|----------------|
| Liver Disease | _____ | _____ | _____ |
| Kidney Disease | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ |
| Asthma | _____ | _____ | _____ |
| Arthritis | _____ | _____ | _____ |
| Hypertension | _____ | _____ | _____ |
| Hypo/hyperthyroid | _____ | _____ | _____ |
| Cancer | _____ | _____ | _____ |
| HIV/AIDS | _____ | _____ | _____ |
| Other: _____ | | | |

Psychiatric/Developmental

| <u>Condition</u> | <u>Paternal Side</u> | <u>Maternal Side</u> | <u>Sibling</u> |
|-------------------------------|----------------------|----------------------|----------------|
| Psychiatric hospitalization | _____ | _____ | _____ |
| Depression | _____ | _____ | _____ |
| Bipolar Disorder/Mania | _____ | _____ | _____ |
| Suicide/Suicide Attempts | _____ | _____ | _____ |
| Anxiety | _____ | _____ | _____ |
| OCD | _____ | _____ | _____ |
| Schizophrenia/Psychosis | _____ | _____ | _____ |
| Conduct Disorder | _____ | _____ | _____ |
| Oppositional Defiant Disorder | _____ | _____ | _____ |
| ADHD | _____ | _____ | _____ |
| Tourette's Syndrome | _____ | _____ | _____ |
| PDD/Aspergers/Autism | _____ | _____ | _____ |
| Learning Disorder | _____ | _____ | _____ |
| Speech/Language Disorder | _____ | _____ | _____ |
| Substance Abuse | _____ | _____ | _____ |
| Other: _____ | | | |

Child/Adolescent Medical History

Other than routine checkups, is your child currently under the care of a physician?
 Yes No If yes, for what is your child being treated? _____

Current medical conditions: _____

Past medical conditions: _____

Does your child have any allergies to foods, animals, or pollens? Yes No

If yes, please specify: _____

Has your child ever had a serious reaction or anaphylaxis? Yes No If yes, please explain: _____

Past hospitalizations? Yes No

If yes, please provide dates and reasons for admission: _____

Past surgeries? Yes No If yes, please specify: _____

Please note any other important or unusual aspects of your child's health or medical history: _____

Medication History

Please list any medications your child is currently taken or has taken in the past, listing most recent first. Please provide prescribing physician's name.

| Medication | Dosage | Purpose | Start/End Date | Prescribing MD |
|------------|--------|---------|----------------|----------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Allergies to medications: Yes No If yes, please specify: _____

Developmental History

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

Describe any complications that were experienced during pregnancy or delivery of your child: _____

Was there any post-natal complications (i.e., low birth weight, jaundice)? Yes No

If yes, please explain: _____

Was your child born prematurely? Yes No

If yes, please provide details (i.e., birth weight, gestational age): _____

What was your child's temperament like as an infant/toddler? _____

Developmental Milestones:

Sitting: Age: _____ Crawling: Age: _____ Walking Age: _____

First words Age: _____ Full Sentences Age: _____ Toileting Age: _____

Have there been any notable problems with hearing or vision? Yes No

If yes, please explain: _____

Please describe any concerns you have regarding your child's development: _____

Child/Adolescent Psychiatric History

| <u>Condition</u> | <u>Yes</u> | <u>No</u> | <u>Specify/Details</u> |
|-------------------------------|-------------------|------------------|-------------------------------|
| Psychiatric hospitalization | _____ | _____ | _____ |
| Depression | _____ | _____ | _____ |
| Bipolar Disorder/Mania | _____ | _____ | _____ |
| Suicide/Suicide Attempts | _____ | _____ | _____ |
| Anxiety | _____ | _____ | _____ |
| OCD | _____ | _____ | _____ |
| Schizophrenia/Psychosis | _____ | _____ | _____ |
| Conduct Disorder | _____ | _____ | _____ |
| Oppositional Defiant Disorder | _____ | _____ | _____ |
| ADHD | _____ | _____ | _____ |
| Tourette's Syndrome | _____ | _____ | _____ |
| PDD/Aspergers/Autism | _____ | _____ | _____ |
| Learning Disorder | _____ | _____ | _____ |
| Speech/Language Disorder | _____ | _____ | _____ |
| Substance Abuse | _____ | _____ | _____ |
| Other: _____ | _____ | _____ | _____ |

Educational History

Current school attending: _____
 Current or highest grade completed: _____
 Current Academic/Behavioral Concerns: _____

Past Academic/Behavioral Concerns: _____

Does your child receive special education services or have a 504 plan/IEP? Yes No
 If yes, please explain: _____

Social History

What do you view as some of your child's strengths, resources, and talents? _____

Who or what are some of the people or activities that your child finds supportive or encouraging? _____

How many close friends does your child have? _____

How often, and about how many hours per week does your child play or spend time with other children? _____

Has your child ever experienced any of the following social problems?

Verbal aggression ___ Comments: _____
 Physical aggression ___ Comments: _____
 Withdrawal behavior ___ Comments: _____
 Rejection ___ Comments: _____
 Being teased/bullied ___ Comments: _____
 Atypical play behavior ___ Comments: _____
 Fire setting behavior ___ Comments: _____
 Stealing in/outside home ___ Comments: _____
 Hurting/torturing animals ___ Comments: _____
 Sexualized acting out ___ Comments: _____

Service Utilization History

Previous psychiatric diagnoses: _____

Current social, emotional, behavioral, or psychiatric concerns: _____

Please list your child's **current** providers:

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Therapist: _____ Phone: _____

Please list your child's **past** providers:

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Therapist: _____ Phone: _____

Note: *I will not contact these providers without your written permission. Please be sure to sign a Release of Information Form if you would like me to speak with and/or provide information to any of your child's past or current providers. One form must be completed for each provider.*

Please check all services previously provided by your child:

Medical diagnostic services: **Date,** **Type of service,** **Providers:**

My child has not used any of these services

Pediatric specialty consultation/exam _____ _____

Genetic testing _____ _____

Other: _____

Medical treatment services:

My child has not used any of these services

Emergency room visits _____ _____

Hospitalization _____ _____

Extended outpatient treatment _____ _____

Surgery _____ _____

Other: _____

Evaluation/diagnostic services:

- My child has not used any of these services*
- Primary care physician evaluation _____
- Genetic testing _____
- Psychological/psychiatric evaluation _____
- Psychological testing _____
- Other: _____

Inpatient psychiatric treatment services: Date, Type of service, Providers:

- My child has not used any of these services*
- Inpatient psychiatric hospitalization _____
- Psychiatric day-treatment _____
- Residential psychiatric treatment _____
- Medication Management: _____
- Other: _____

Outpatient psychological/psychiatric treatment services:

- | | <u>Date,</u> | <u>Type of service,</u> | <u>Providers:</u> |
|---|--------------|-------------------------|-------------------|
| <input type="checkbox"/> <i>My child has not used any of these services</i> | | | |
| <input type="checkbox"/> Individual psychotherapy | _____ | _____ | _____ |
| <input type="checkbox"/> Conjoint (with parent) psychotherapy | _____ | _____ | _____ |
| <input type="checkbox"/> Family psychotherapy | _____ | _____ | _____ |
| <input type="checkbox"/> Group psychotherapy for children | _____ | _____ | _____ |
| <input type="checkbox"/> Group psychotherapy for parents | _____ | _____ | _____ |
| <input type="checkbox"/> Parent education classes | _____ | _____ | _____ |
| <input type="checkbox"/> Medication management | _____ | _____ | _____ |
| <input type="checkbox"/> Other: _____ | | | |

Educational services:

- My child has not used any of these services*
- Individual Education Plan (IEP) _____
- Special Education _____
- Tutoring _____
- Other: _____

Additional services:

- My child has not used any of these services*
- Speech and language therapy _____
- Occupational therapy _____
- Physical therapy _____

- Sensory integration therapy _____
- Biofeedback _____
- Hypnosis _____
- Other: _____

Social services:

- My child has not used any of these services*
- Foster care _____
- Department of Child and Family Services _____
- Social Work _____
- Homeless shelter _____
- Domestic violence shelter _____
- Juvenile detention center _____
- Juvenile probation _____
- Other: _____

What character traits do you love about your child?

What are your goals for your child/family in therapy?

For staff use

Therapist's signature/credentials: _____ Date: _____

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Physical exam : _____ required _____ Not required

Therapist comments:
