

CEDAR CENTRE INTAKE INFORMATION

This information is important in evaluation and treatment of you child. Please fill out the following questionnaire as completely as possible.

CHILD'S FULL NAME: _____

DATE OF BIRTH: _____

WITH WHOM IS THE CHILD LIVING: _____

RELATION TO CHILD: _____

MOTHER'S FULL NAME: _____ AGE: _____

OCCUPATION: _____

LAST GRADE OF SCHOOL COMPLETED: _____

FATHER'S FULL NAME: _____ AGE: _____

OCCUPATION: _____

LAST GRADE OF SCHOOL COMPLETED: _____

SCHOOL CHILD IS PRESENTLY ATTENDING: _____ GRADE: _____

IS CHILD IN A PROGRAM, SUCH AS: LD _____ BD _____ PDC _____

CHILD EVER BEEN PSYCHOLOGICALLY TESTED? _____ IF YES, BY WHOM: _____

HAVE YOU USED ANY OTHER SERVICES RELATED TO YOUR CHILD'S BEHAVIOR AND/OR FAMILY PROBLEMS? _____ IF SO, LIST: _____

PLEASE LIST ALL OTHER CHILDREN IN THE FAMILY. NOTE IF ANY HAVE A PROBLEM WITH HEALTH, LEARNING OR BEHAVIOR:

FULL NAME	AGE	RELATION (natural, step adopted, foster)	WHERE LIVING	PROBLEM
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HAS YOUR CHILD EVER BEEN HOSPITALIZED FOR ANY REASON (EXCEPT BIRTH)? _____ IF YES:

DATE WHERE REASON TREATMENT

HAS YOUR CHILD EVER HAD ANY SERIOUS ILLNESSES / ACCIDENTS?

DATE ILLNESS / ACCIDENT

IS YOUR CHILD CURRENTLY TAKING MEDICATIONS? IF YES,

NAME DOSAGE PRESCRIBED BY

DOES YOUR CHILD HAVE ANY ALLERGIES? _____

BIRTH INFORMATION

BIRTH WEIGHT: _____

BORN EARLY/LATE? _____ IF YES, BY HOW MUCH? _____

DID THE CHILD HAVE TO STAY IN THE HOSPITAL AFTER MOTHER WAS DISCHARGED? _____ HOW LONG? _____

FOR WHAT REASON? _____

HAS MOTHER HAD ANY MISCARRIAGES? _____ HOW MANY? _____

HAS MOTHER HAD ANY STILLBORN CHILDREN? _____

DID MOTHER HAVE ANY OF THE FOLLOWING COMPLICATIONS DURING PREGNANCY? (please check all that apply)

FLU ___ SURGERY ___ X-RAYS ___ SPOTTING / BLEEDING ___

THREATENED MISCARRIAGE ___ OTHER _____

DID MOTHER TAKE ANY MEDICATIONS DURING PREGNANCY (other than vitamins)? _____ IF YES, WHAT _____

Cedar Centre Psychiatric Group – Please provide medical information as best you can

Name: _____ DOB: _____ Date: _____

Allergies: _____

Medications (include herbs, supplements, vitamins, over the counter, eye drops, ALL medications please):

Past psychiatric medications:

Hospitalizations/Surgeries (include all medical/psychiatric, year and reason):

Have you ever had the following:

Birth Injury(Blue baby): NO YES(explain): _____

Head injuries: NO YES(explain): _____

Loss of consciousness or concussions? NO YES(explain): _____

Seizures: NO YES(explain): _____

Meningitis or Encephalitis: NO YES(explain): _____

ECT(shock treatments): NO YES(explain): _____

Serious Accidents: NO YES(explain): _____

Do you smoke: NO YES

Do you drink alcohol: NO YES

Do you have any problems with the following (if you do, please circle and describe below):

Constitution: Fever, Chills, Sleep problems, Appetite or weight changes

HEENT: Vision, glaucoma, hearing problems, smelling problems, taste or swallowing problems

Blood and Immune: weak immune system, allergies, HIV/Aids, bleeding disorder, lymph disorder, cancer

Neurologic: Headache, Tremor, Dizzy, Numbness, Multiple Sclerosis, Parkinson's, Dementia, Memory problems, Restless legs, Seizures, Stroke, Brain or spinal injury or infection, Pinched nerves

Hormones: Fatigue, Tired, Excessive sweating, Hot flashes, Libido changes, Thyroid, Diabetes, Menopause

Gastrointestinal: Abdominal pain, Nausea, Vomiting, Diarrhea, Constipation, Blood in stools, Hepatitis

Cardiovascular: Chest pain, Palpitations, Heart attacks, Heart murmurs, Heart failure, fatigue with activity

Pulmonary: Asthma, COPD, Emphysema, Chronic cough, Wheezing, Coughing up blood

Rheumatology: Fibromyalgia, Chronic Fatigue, Arthritis, Lupus

Skin: Rashes, Easy bruising, Eczema, Psoriasis, Acne, breast problems

Musculoskeletal: Joint problems, Stiffness, Osteoporosis, Muscle or bone diseases, sciatica

Genitourinary: Kidney problems, Urine problems, blood in urine, prostate problems, genital infection

Other details or problems: _____

Are you pregnant? NO YES Are you intending to become pregnant while in treatment? NO YES

Patient (or Guardian) Signature

Provider Signature