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: _____

DOES YOUR CHILD HAVE A 504 PLAN, IEP, OR OTHER ACCOMMODATIONS? _____

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**

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 _____

BIRTH INFORMATION continued

AGE CHILD FIRST SAT: _____ WALKED: _____

TOILET TRAINED: _____ SAID FIRST WORDS: _____

HAVE ANY BLOOD RELATIVES OF THE CHILD EXPERIENCED THE FOLLOWING? (check all that apply):

SUICIDE____ ATTEMPTED SUICIDE____ ANXIETY____ DEPRESSION____

SCHIZOPHRENIA____ LEARNING DISABILITIES____ LEGAL PROBLEMS ____

INTELLECTUAL IMPAIRMENT____ DEVELOPMENTAL DELAY ____ ADHD ____

DRUG/ALCOHOL ABUSE____ AUTISM ____

NAME OF PERSON / AGENCY WHO SUGGESTED REFERRAL: _____

_____

PLEASE SUMMARIZE YOUR CONCERNS BELOW (turn sheet if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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**