

Cedar Centre Psychiatric Group Child/Adolescent Intake Form

This information is important in evaluation and treatment of your child.

Please fill out the following questionnaire as completely as possible.

Child's Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: Male Female

Your Name: _____ Relationship to Patient _____

Who referred you to this clinic? _____

Please list the reasons that bring you here today. They may include certain problems, issues, significant losses or changes that are causing you stress.

1. _____
2. _____
3. _____

Please list the goal(s) you hope to achieve in treatment? What do you hope treatment will help your child to change?

1. _____
2. _____

Has your child seen a therapist or counselor before? Yes No Or a psychiatrist? Yes No

If yes: Therapist/Counselor/Psychiatrist Dates (from/to) Problem/Area of Concern

Please check all that apply to your child:

- | | | |
|--|---|--|
| <input type="checkbox"/> withdrawn | <input type="checkbox"/> depression | <input type="checkbox"/> decreased energy and motivation |
| <input type="checkbox"/> increased aggression | <input type="checkbox"/> irritable | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> bedwetting | <input type="checkbox"/> non-compliant |
| <input type="checkbox"/> anger outbursts | <input type="checkbox"/> oppositional | <input type="checkbox"/> fire setting |
| <input type="checkbox"/> physical abuse issues | <input type="checkbox"/> sexual abuse | <input type="checkbox"/> perfectionist tendencies |
| <input type="checkbox"/> change in friends | <input type="checkbox"/> obsessions | <input type="checkbox"/> feelings of hopelessness |
| <input type="checkbox"/> hyperactive | <input type="checkbox"/> thoughts of hurting self | <input type="checkbox"/> other |
| <input type="checkbox"/> school difficulties | <input type="checkbox"/> thoughts of hurting others | |

Please list any recent major family changes, losses, separation, deaths, moves, etc.

Has your child ever been hospitalized for emotional problems? Yes No

Has your child ever been in a drug/alcohol treatment program? Yes No

Family/Relationship History:

Mother: _____ Age: _____ Occupation: _____

Father: _____ Age: _____ Occupation: _____

Family/Relationship History (continued)

Siblings: Name Sex Age Full/Half/Step

Who lives in the household with the child? _____

Is there currently a change in custody, visitations, or a pending divorce? Yes No

Do any members of the child’s family suffer from major health problems at this time? _____

Have any blood relatives of the child experienced the following? (check all that apply)

- suicide schizophrenia learning disabilities other addictive behaviors
 depression legal problems attempted suicide other mental health issues
 anxiety mental retardation drug/alcohol abuse

Any history of abuse in your child’s family? Emotional Verbal Physical Sexual

Has your child ever been abused? Emotional Verbal Physical Sexual

If yes, was this investigated? Yes No Are there any guns in your home? Yes No

Is your child or anyone in the child’s family currently involved with the court or legal system? Yes No

Is your family currently involved with social services or the Department of Human Services (DHS)? Yes No

Medical History:

Primary Care Clinic: _____ Doctor: _____

Last Medical Exam: _____ Past hospitalizations, surgeries, medical issues: _____

Current Medical Conditions: _____

Current Prescribed Medications: _____

Allergies: _____

Developmental History:

Birth Weight: _____ Born how many days early or late? _____

Did the child have to stay in the hospital after mother was discharged? Yes No How Long? _____

For what reason? _____

How many miscarriages has mother had? _____ Stillborn children? _____

Did mother have any of the following complications during pregnancy? (check all that apply)

- flu surgery x-rays spotting/bleeding threatened miscarriage other: _____

What medications did mother take during pregnancy (other than vitamins)? _____

Age child sat: _____ walked: _____ toilet trained: _____ spoke first words: _____

Was the child separated from his/her biological parent(s) for a significant period of time? Yes No

How long was the separation? _____ Reason: _____

Have you or another adult had any concerns about your child's development in any of the following areas?

Evaluated by:

_____ speech and language development _____

_____ hearing _____

_____ vision _____

_____ intelligence/ability to learn _____

_____ bladder/bowel control _____

_____ emotional/maturity level _____

_____ social skills _____

_____ eating habits _____

fine motor skills (write, color, etc) _____

gross motor skills (walk, run, etc) _____

Does your child have any physical disabilities or limitations of movement, sight, or hearing? Yes No

If yes, please explain: _____

Education/Work:

Grade in School: _____ School name: _____

Special placement (if any): _____

Leisure/Recreation:

What does your child enjoy doing in his/her spare time? _____

How often does he/she engage in these activities? _____

Spirituality:

Spiritual/Religious Affiliation: _____

Finances:

How much is money and debt a problem in the life of this child's family?

Not at all	A little bit		Moderately			A lot		A Great Deal		
0	1	2	3	4	5	6	7	8	9	10

THANK YOU FOR COMPLETING THIS INFORMATIONAL QUESTIONNAIRE!

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