Center for Life Strategies LLC

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CHILD/ADOLESCENT INTAKE FORM

Today's date: _____

Patient Information:

Individual Name: _____ Date of Birth: _____ Age: _____
(first) (last)

Gender M/F Ethnicity (optional): _____

Name of Person completing this form: _____

Relationship to individual: _____ Years known: _____

Residence of child: (circle) Biological parents Adoptive parents Foster parents PCS Home

Other: _____

Patient Contacts:

Mother's name: _____ Age: _____
(first) (last)

Father's name: _____ Age: _____
(first) (last)

Marital Status of Parents: (circle) Married Divorced Separated Widowed

Mother's Address: _____
(street) (city) (state) (zip code)

Father's Address: _____
(street) (city) (state) (zip code)

Contact phone numbers:

Name/Relationship: _____ Number: _____

Who has legal/physical custody? _____ Type: _____
(please provide legal documentation)

Support Services:

Does this individual receive services from Health and Welfare? Yes No

Case Worker (name): _____ Phone: _____

Services Received: _____ Region: _____

Referral Information:

Who referred you to this clinic?

_____
(name) (phone)

(address)

Presenting Problem:

What concerns you most about this individual?

When did you first notice this problem?

How has this problem affected his/her function?

At home:

At school/work:

Community:

Do you have other concerns you want addressed?

What are your goals/expectations for treatment?

Have you recently worried that your child has (please circle items relevant to your child):

Yes No DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)

Yes No MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)

Yes No ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)

Yes No BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)

Yes No ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)

Yes No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

Yes No SOCIAL ANXIETY (shy and/or afraid to be around others)

Yes No REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)

Yes No AUTISM (social and language impairments, rigidity)

Yes No PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)

Yes No DISSOCIATION (feeling outside your body or things are not real, etc.)

Yes No Has your child ever harmed themselves intentionally? Attempted suicide? Harmed others?

Sleep Patterns:

Total hours of sleep per night: Usual Schedule: to

Does the individual take naps during the day? Yes No
If Yes, how many hours in a typical day?

Concerns:	Current Problem		Change within last 6 months	
Difficulty falling asleep:	Yes	No	Yes	No
Frequent awakening:	Yes	No	Yes	No
Snoring:	Yes	No	Yes	No
Restlessness/Movements:	Yes	No	Yes	No
Early morning awakening:	Yes	No	Yes	No
Nightmares:	Yes	No	Yes	No
Not rested:	Yes	No	Yes	No

If yes to any of the concerns listed above, please describe:

Past Psychiatric History: residential, or day treatment programs (including any

Please list any previous psychiatric hospitalizations, alcohol and drug treatment programs)

Diagnosis	*Length of Stay*	*Treatment*	*Response*

Please list any current or prior outpatient psychiatrists and therapists your child has seen?

Name	*Title*	*Location*	*How Long?*

Please list this individual's current psychiatric medications. (You may refer to the list of medications on the next page)

Name *Dosage* *Duration* *Response*

Please list this individual's current non-psychiatric medications.

Name *Dosage* *Duration* *Response*

Please list all the psychiatric medications that have been tried in the past (if greater than 4 medications please attach separate list). *(You may refer to the list of medications on the next page).*

Name *Highest Dosage* *Duration* *Response* *Reason for Stopping*

Example: Dexedrine, 5 mg twice daily, 09/98-11/98, good, poor sleep

Drug and Alcohol History:

Substance	Date of Last Use	Problems Related to Use		Treatment Required	
Benzodiazepines (Valium, Xanax, Ativan)		Yes	No	Yes	No
Caffeine		Yes	No	Yes	No
Marijuana		Yes	No	Yes	No
Cocaine		Yes	No	Yes	No
Designer Drugs (Club Drugs: G, X)		Yes	No	Yes	No
Hallucinogens (LSD, Mushrooms)		Yes	No	Yes	No
Inhalants (Gasoline, Glue, Aerosol)		Yes	No	Yes	No
Methamphetamines (Speed, Ice, Ritalin)		Yes	No	Yes	No
Opiates/Methadone (Vicodin, OxyContin, Heroin)		Yes	No	Yes	No
OTC – *Over the counter* (Benadryl, Nyquil, Dramamine)		Yes	No	Yes	No

Tobacco none per day:

Is there anything else we should know about any drug history?

Patient Name: _____ DOB _____

Adderall® (dextroamphetamine + amphetamine)

Abilify® (aripiprazole)

Adipex-P® (phentermine)

Ambien® (zolpidem)

amitriptyline (Elavil®)

Amoxapine

Antabuse® (disulfiram)

Anafranil® (clomipramine)

Aricept® (donepezil)

Ativan® (lorazepam)

Aventyl® (nortriptyline)

Benadryl® (diphenhydramine)

Buspar® (buspirone)

Carbatrol® (carbamazepine)

Catapres® (clonidine)

Celexa® (citalopram)

Chloral hydrate

Clozaril® (clozapine)

Cogentin® (benztropine)

Concerta® (methylphenidate)

Cymbalta® (duloxetine)

Cylert® (pemoline)

Dalmane® (flurazepam)

Depakote®/Depakene® (valproic acid/ valproate)

Dexedrine® (dextroamphetamine)

Didrex® (benzphetamine)

Dilantin® (phenytoin)

Dolophine®/Methadose® (methadone)

Effexor XR® (venlafaxine)

Elavil® (amitriptyline)

Ephedra®

Eskalith® (lithium)

Evening primrose oil

Focalin® (dexmethylphenidate)

Gabitril® (tiagabine)

Geodon® (ziprasidone)

Ginkgo biloba

Ginseng

Halcion® (triazolam)

Haldol® (haloperidol)

imipramine (Tofranil®)

Inderal® (propranolol)

Keppra® (levetiracetam)

Klonopin® (clonazepam)

Lamictal® (lamotrigine)

Lexapro® (escitalopram)

Librium® (chlordiazepoxide)

Lithobid® (lithium)

Loxitane® (loxapine)

Luminal® (phenobarbital)

Luvox® (fluvoxamine)

Melatonin

Mellaril® (thioridazine)

Marplan® (isocarboxazid)

Meridia® (sibutramine)

Metadate® (methylphenidate)

Methylin® (methylphenidate)

Moban® (molindone)

Mysoline® (primidone)

Nardil® (phenelzine)

Navane® (thiothixene)

Neurontin® (gabapentin)

Norpramin® (desipramine)

nortriptyline (Pamelor®)

Omega fatty acids

Orap® (pimozide)

Pamelor® (nortriptyline)

Parnate® (tranylcypromine)

Paxil® (paroxetine)

Periactin® (cyproheptadine)

Prolixin® (fluphenazine)

propranolol (Inderal®)

ProSom® (estazolam)

protriptyline (Vivactil®)

Provigil® (modafinil)

Prozac® (fluoxetine)

Remeron® (mirtazapine)

Restoril® (temazepam)

ReVia® (naltrexone)

Risperdal® (risperidone)

Ritalin® (methylphenidate)

SAM-e

Saint john's wort

Sarafem® (fluoxetine)

Serax® (oxazepam)

Seroquel® (quetiapine)

Serzone® (nefazodone)

Sinequan® (doxepin)

Sonata® (zaleplon)

Stelazine® (trifluoperazine)

Strattera® (atomoxetine)

Subutex® (buprenorphine)

Suboxone® (buprenorphine + naloxone)

Symbiax® (olanzapine + fluoxetine)

Tegretol® (carbamazepine)

Tenex® (guanfacine)

Tenuate® (diethylpropion)

Thorazine® (chlorpromazine)

Tofranil® (imipramine)

Topamax® (topiramate)

Tranxene® (clorazepate)

trazodone (Desyrel®)

Trilafon® (perphenazine)

Trileptal® (oxcarbazepine)

Valerian

Valium® (diazepam)

Vistaril® (hydroxyzine)

Wellbutrin® (bupropion)

Xanax® (alprazolam)

Zarontin® (ethosuximide)

Zoloft® (sertraline)

Zonegran® (zonisamide)

Zyprexa® (olanzapine)

Zydis® (olanzapine)

Patient Name: _____ DOB _____

Family History:

Consider this individual's immediate family and all of their relatives on both sides (parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins)

Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Uncle") and their treatment history (if applicable). Maternal is mother's side of the family and Paternal is father's side of the family.

_____ Depression _____
_____Anxiety _____
_____ADHD _____
_____Bipolar (manic depressive) _____
_____Schizophrenia _____
_____Alcohol/Drug Problems _____
_____Learning Disabilities _____
_____Autism/Asperger/Pervasive Developmental Disorder _____
_____ Mental Retardation _____
_____"Nervous Breakdown" _____
_____ Psychiatric Hospitalizations _____
_____ Suicide (or attempts) _____
_____ Panic Disorder _____
_____PTSD (Post Traumatic Stress Disorder) _____
_____OCD (Obsessive Compulsive Disorder) _____
_____ Seizures _____
_____ Migraines _____
_____Heart or lung problems _____
_____Thyroid _____
_____Immunological disorders (lupus, scleroderma, inflammatory bowel disease) _____
_____Cancer _____
_____Other _____

Developmental History:

Did your child achieve the following milestones early (E), average (A), or late (L) compared with others his/her age (please explain if late):

_____ Language (age at first using words, sentences, etc...)?

_____

_____ Fine motor skills (building towers with cubes, drawing circle)

_____

_____ Gross motor skills (rolling over, standing, walking)?

_____

_____ Toilet training?

_____

Has your child experienced any regression of these? Yes No If yes, explain: _____

_____

_____

Pregnancy and Birth History:

How old was this child's biological parents when he/she was conceived?

Was this the biological mother's first pregnancy? Yes No

If no, how many times was she pregnant before this pregnancy?

Did the biological mother experience any miscarriages before or after this pregnancy? Yes No

If yes, how many? During what trimester?

When was prenatal care first received (in weeks):

How much weight did the biological mother gain during this pregnancy?:

Baby's birth weight and length:

Length of pregnancy (in weeks):

Did the mother have any ultrasounds or amniocentesis? Yes No If yes, please describe the reason for these and the results:

Please indicate whether any of the following events/problems occurred during this pregnancy. Please include the trimester in which the event occurred, as well as any other important details.

	Yes / No	# of months into pregnancy	Additional details
Infections/Colds	Yes No		
Fevers	Yes No		
Hospitalizations	Yes No		
Vaginal Bleeding, Spotting	Yes No		
Problems with Diet	Yes No		
Pregnancy Induced Hypertension	Yes No		
High Blood Pressure, Excessive Swelling	Yes No		
Diabetes	Yes No		
Rh or Blood Incompatibilities	Yes No		
Trauma (Emotional Stress and/or Physical Injury)	Yes No		

Did you take any medications (prescription and over the counter) during this pregnancy? (If yes, please complete the following table.)

Medication	Month(s) taken (1-9)	Dose	Reason for taking

Did you consume alcohol during this pregnancy? Yes No
If yes, how much and how often?

Did you smoke or use tobacco products during this pregnancy? Yes No
If yes, please describe how much and how often?

Did you use any drugs during this pregnancy? Yes No
If yes, please name drug(s), how much and frequency of use:

Labor Information:

Type of delivery (c-section, vaginal):

Were forceps used?

Were there any problems with the baby's health right before or immediately after delivery? Yes No
If yes, please describe:

Were the mother and/or baby separated after birth for more than 24 hours at a time? Yes No
If yes, please explain:

Past Medical History:

Primary Care Provider: Years Involvement:

Phone:

Address:

Approximate Date of Last Visit:

Number of Visits in Last Year:

Other Provider(s):

Specialty:

Name: Phone:

Address:

Other Provider(s):

Specialty:

Name: Phone:

Address:

Allergies (drug, food, seasonal, environmental etc.)? Yes No If yes, please name and describe your child's reaction:

Has your child ever experienced a head injury, loss of consciousness, or seizure? Yes No
If yes, please describe:

Does your child have any chronic medical problems? Yes No If yes, please describe:

Does your child have a history of any serious injuries or medical hospitalizations? Yes No
If yes, please describe:

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? Yes No
If yes, please describe:

Have you recently worried that your child may have problems with:

Heart	Constipation/Diarrhea	Age of first menses
Lungs	Frequent infections	Regular o r Irregular cycle
Kidneys/Bladder	Endocrine (i.e., diabetes; thyroid dysregulation; excessive hair growth)	
Neurological	Immunizations up to date	

Has your child ever had an EEG, MRI, CT SCAN, etc? Yes No

If yes, why was it done and were the results normal?

If yes, where were the tests performed and who ordered them?

Social History:

Is your child your biological child? Yes No
If no, at what age was he/she adopted?

Is there any contact with their biological parent(s)?

Where was your child born and raised?

Has your child moved a number or times? Yes No

If yes, please list their age at time of move and location:

Parents: (Including Step-Mother and Step-Father, if applicable)

Name	*Education*	*Occupation*	*Hrs/Wk*	*Relationship with Child (quality)*

Please list the other children in the family and other household members who may also be living in your home:

Name	*Age*	*Lives a t Home?*	*Relation to Child*	*Relationship with Child*

Abuse History:

Has your child ever been the victim of abuse or neglect? Yes No

If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical	Emotional	Neglect
Accidents	Disasters	Sexual
Witnessing violence	Other:	

Are you struggling with your marital relationship or parenting? Yes No

If yes, please describe:

Has your child ever been involved with the following and if yes, please explain:

Yes	No	Child Protective Services
Yes	No	Childrens Mental Health
Yes	No	Probation/Juvenile Probation/Detention
Yes	No	Boys and Girls Club
Yes	No	Youth Services
Yes	No	Head Start
Yes	No	Early Intervention Services (ages 0-3)

School:

Where does your child attend school?

In what grade level is he/she?

What are his/her typical grades?

What are your child's academic strengths?

Academic weaknesses?

Has there been a change in your child's performance at school? Yes No If yes, please describe:

Has your child received IQ or Academic testing? Yes No If yes, what were the results?

Does or has your child participated in any of the following?

Yes No Resource (for which classes/how many hours?)

Yes No Accelerated or Honors programs, explain:

Yes No 504 Plan, explain:

Yes No Individual Education Plan (IEP), explain:

Yes No Virtual Academy, explain:

Has your child had problems with any of the following?

Yes No Truancy, explain:

Yes No Fights, explain:

Yes No Absenteeism, explain:

Yes No Detention, explain:

Yes No Suspension, explain:

Yes No School refusal, explain:

What are your child's favorite activities?

Peers:

Does your child have quality relationships with other children? Yes No If no, please explain:

Culture:

Do you have a religious preference in the household? Yes No If yes, what is that preference?

Has your child experienced any problems related to race, religion, or culture? Yes No If yes, please explain:

TEEN/YOUNG ADULT SECTION

Do you have any concerns regarding your adolescent's friendships? Yes No
(Please circle all that apply.)

Too old	Too young	Truant	Gang	Fringe
Drug/alcohol use	Violence	Too many	Too few	Sexual Promiscuity
Too much time together	Other			

Has your adolescent had a recent change in friendships? Yes No If yes, what changes, if any are concerning to you?

Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? Yes No If yes, please describe:

Are you concerned about your child's sexual activities? Yes No

Is your adolescent sexually active? Yes No

Does your adolescent have a job? Yes No

Has your adolescent's behavior ever resulted in police, detention, or court involvement? Yes No
If yes, please explain:

Is there anything else you would like us to know about your child?

Patient Name: _____ DOB _____