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:

__ withdrawn	__ depression	__ decreased energy and motivation
__ increased aggression	__ irritable	__ nightmares
__ crying spells	__ bedwetting	__ non-compliant
__ anger outbursts	__oppositional	__ fire setting
__ physical abuse issues	__ sexual abuse	__ perfectionist tendencies
__ change in friends	__ obsessions	__ feelings of hopelessness
__ hyperactive	__ thoughts of hurting self	__ other
__ school difficulties	__ 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 __ developmental delay __ drug/alcohol abuse __ intellectual impairment

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**