

Child/ Adolescent Confidential Mental Health Intake Form

Date: _____

Please complete the following information about your child and bring the completed form to your first appointment.

Patient's Name: _____ Date of Birth: _____

Name of parent(s) or guardian(s) who have legal custody of child:

Patient's Emergency Contact: _____

Phone: _____ Relationship to patient: _____

Name all the people with who live with your child, and their relationship to him/her:

Child's School: _____

Grade/ Year: _____

Coordination of Care

Who referred you to me? _____

Do you wish for me to coordinate with your child's other providers? Yes* No

If yes, whom? _____

*If you would like me to share your child's health information with anyone other than his/her custodial parents/legal guardians, you will need to complete a Release of Information that authorizes me to do so.

Chief Concerns

Please describe briefly what brings you to see me:

What are the three biggest concerns you have for your child right now?

- 1. _____
- 2. _____
- 3. _____

What are your goals for your child’s treatment? What changes would you like to see?

Is your child bothered by problems with sleep? Yes No

Please describe: _____

Is your child bothered by hearing or seeing things, or by voices? Yes No

Please describe: _____

Does your child have difficulty with focusing on tasks or finishing things? Yes No

Please describe: _____

Psychiatric History

Is your child currently receiving any type of psychotherapy or counseling? Yes No

If yes, by whom? _____ Phone: _____

Does your child have a history of mental health problems or hospitalizations? Yes No

If so, please complete the following:

Diagnosis	Dates Treated	By Whom
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Most parents have thoughts or opinions about the use of psychiatric medications treat children. Please explain your views on mental health medications for your child:

Medications taken previously (if any):

My child has never taken medication

Please check the box for each medication your child has tried in the past. Next to the name of the medication, please write the dose they were prescribed and for how long they tried it.

- | | |
|---|---|
| <input type="checkbox"/> Prozac (fluoxetine) | <input type="checkbox"/> Tenex (guanfacine) |
| <input type="checkbox"/> Zoloft (sertraline) | <input type="checkbox"/> Vistaril (hydroxyzine) |
| <input type="checkbox"/> Luvox (fluvoxamine) | <input type="checkbox"/> Xanax (alprazolam) |
| <input type="checkbox"/> Paxil (paroxetine) | <input type="checkbox"/> Ativan (lorazepam) |
| <input type="checkbox"/> Celexa (citalopram) | <input type="checkbox"/> Restoril (temazepam) |
| <input type="checkbox"/> Lexapro (escitalopram) | <input type="checkbox"/> Klonopin (clonazepam) |
| <input type="checkbox"/> Effexor (venlafexine) | <input type="checkbox"/> Valium (diazepam) |
| <input type="checkbox"/> Pristiq (desvenlafexine) | <input type="checkbox"/> Ambien (zolpidem) |
| <input type="checkbox"/> Cymbalta (duloxetine) | <input type="checkbox"/> Buspar (buspirone) |
| <input type="checkbox"/> Wellbutrin (bupropion) | <input type="checkbox"/> Adderall (amphetamine) |
| <input type="checkbox"/> Desyrel (trazodone) | <input type="checkbox"/> Concerta (methylphenidate) |
| <input type="checkbox"/> Remeron (mirtazapine) | <input type="checkbox"/> Ritalin (methylphenidate) |
| <input type="checkbox"/> Tegretol (carbamazepine) | <input type="checkbox"/> Strattera (atomoxetine) |
| <input type="checkbox"/> Lithium | <input type="checkbox"/> Vyvanse (lisdexamphetamine) |
| <input type="checkbox"/> Depakote (valproate) | <input type="checkbox"/> Focalin (dexmethylphenidate) |
| <input type="checkbox"/> Lamictal (Lamotrigine) | <input type="checkbox"/> Daytrana patch (methylphenidate patch) |
| <input type="checkbox"/> Topamax (topiramate) | <input type="checkbox"/> Tenex (guanfacine) |
| <input type="checkbox"/> Seroquel (quetiapine) | <input type="checkbox"/> Intuniv (guanfacine ER) |
| <input type="checkbox"/> Risperdal (risperidone) | <input type="checkbox"/> Clonidine |
| <input type="checkbox"/> Zyprexa (olanzapine) | <input type="checkbox"/> Neurontin (gabapentin) |
| <input type="checkbox"/> Geodon (ziprasidone) | <input type="checkbox"/> Emsam (selegiline patch) |
| <input type="checkbox"/> Abilify (aripiprazole) | <input type="checkbox"/> Other medications: |

Medical Information

Allergies: _____

Current prescription medications:

Medicine	Dosage	Frequency	Prescribed by

Current over the counter medications, herbal remedies, and nutritional supplements:

Current medical problems: _____

Past medical problems, hospitalizations, and surgeries:

Do you have any other concerns about your child’s health that you’d like to discuss with me during our appointment? Yes No

Primary care provider: _____

Date and place of last physical exam: _____

Has your child ever had:

An EKG? (heart) Yes No Date: _____

Please describe: _____

An MRI/ PET/ CT brain scan? Yes No Date: _____

Please describe: _____

An EEG? (monitor for seizures) Yes No Date: _____

Please describe: _____

Check if your child has a history of

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Feeding problems |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Head trauma | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Psychosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Strep infections |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Other: _____ |

Family history

If your child has biological relatives who have experienced the above or other health problems, please describe: _____

Please list all biological relatives who have been diagnosed with the following conditions:

Depression: _____ Anxiety: _____

Anger: _____ Violence: _____

ADHD/ADD: _____ Alcohol abuse: _____

Eating disorder: _____ Drug abuse: _____

Bipolar (manic depressive) _____ Schizophrenia: _____

To your knowledge, has any family member attempted suicide? Yes No

If yes, whom? _____

Has any family member been treated with a psychiatric medication? Yes No

If yes, what medications, and how effective were they?

Substance Use:

Has your child ever been treated for alcohol or drug use or abuse? Yes No

If yes, for which substances? _____

If yes, where were they treated and when? _____

To your knowledge, has your child ever tried alcohol or other drugs? Yes No

Legal History:

Has your child ever been arrested? Yes No

If yes, please explain: _____

Does your child have any pending legal problems? Yes No

If yes, please explain: _____

Developmental History:

Was your child adopted? Yes No If yes, at what age? _____

When your child was born, were there any medical concerns during labor, delivery, or immediately after his/her birth? Yes No Not sure

Please describe: _____

Developmental milestones (sitting up, walking, talking, toilet training, etc.) were:

On time Delayed Earlier than other children Not sure

How many brothers or sisters? How old are they? _____

Mother's occupation? _____ Father's occupation? _____

Has your child experienced parental divorce? Yes No

If so, how old was your child? _____

If so, with whom does your child live? _____

Describe your child's relationship with you: _____

Describe your child's relationship with their other parent (s): _____

What, if any, are your child's responsibilities at home? _____

Trauma History

To your knowledge, was your child ever physically, verbally, or sexually abused? _____

If so, please briefly describe: _____

Has your child ever experienced the loss or death of a close loved one? Yes No

If so, please briefly describe circumstances: _____

Spirituality

Does your family belong to a particular religion or spiritual group: Yes No

If yes, what is the level of your family's involvement? _____

If your family does not belong to a group, does your family have any spiritual beliefs or life philosophy that is particularly important to you? Yes No

Please explain: _____

Educational History:

What school does your child attend? _____

How are his/her grades? _____

Does your child have any identified learning disabilities? _____

If your child has had any specialized academic testing, please describe: _____

How does your child do socially at school? _____

What are your child's best subjects? _____

Worst subjects? _____

What do your child's teachers say about him/her? _____

Recreation

What kind(s) of exercise does your child get? _____

In what after school activities does your child participate? _____

Does your child play video games? Yes No

If so, which ones? _____

How many hours per day? _____ Hours per week? _____

Does your child watch television? Yes No

How many hours per day? _____ Hours per week? _____

Does your child have a television or computer in their bedroom? Yes No

Does your child have their own cell phone? Yes No

How often does your child visit with his or her friends? _____

What do you think about your child's group of friends? _____

What are your child's personal strengths? _____

Other Concerns

Please tell me anything other information that you believe may improve my ability to provide effective care for your child.

Please describe any concerns about your cost of treatment (copay, medication costs, etc.)

Your child's comfort is very important, and some material is better discussed with them not present. Is there anything in the above information that you do not want your child to know?