CONFIDENTIAL

PLEASE TURN IN COMPLETED FORM TO FRONT DESK PERSONNEL

Patient Name: _____ **DOB:** _____

Date: _____

CHILD PSYCHIATRIC ASSESSMENT INTAKE

PRESENTING PROBLEM—in your own words, summarize in one to two brief sentences.

PURPOSE OF VISIT—In your own words, please describe your goals for this assessment in one to two brief sentences.

Please describe any **current stressful event** in the patient's life (home, work, family, social, etc.)

Please circle any problems that you experience: (circle all that apply)

appetite	sleep disturbance	bladder problems	excessive drinking	easily distracted
pain	difficulty waiting	difficulty sitting still	self harm	physically violent to property
stealing	breaking and entering	lying	refusal to attend school	concerns about sexual identity
sibling rivalry	fainting	poor hygiene	negative peer associates	poor relationship with parent
anger	headaches	difficulty relaxing	urinates/soils self	difficulty making friends
drug use	nervousness	fatigue	fears/phobias	obsessive thoughts
confusion	loneliness	anxiety	impulse control	feelings of unreality
nightmares	tense	dizziness	intrusive thoughts	bowel problems
flashbacks	allergies	stomach problems	low self-esteem	impulsive behaviors
depression	suicidal ideations	heart palpitations	difficulty concentrating	

Personal Well-Being

How is the quality of the patient's sleep? _____

Has this changed from the past? If so, how? _____

How is the patient's level of physical activity? _____

Has this changed from the past? If so, how? _____

How is the patient's diet? _____

Has this changed from the past? If so, how? _____

PSYCHIATRIC HISTORY

Psychiatric Hospitalizations (dates, locations, and length of time):

Past psychotherapy / counseling (dates, lengths of time, and focus of treatment):

Present occurring psychotherapy / counseling (dates, lengths of time, and focus of treatment):

Any current treatment by a psychiatrist (dates, length of time, and focus of treatment):

Any past treatments by a psychiatrist (dates, length of time, and focus of treatment):

Any current psychiatric medications: (names, dosages, length of time, purpose of medication, results, and side effects)? Please list all medications separately:

Any past psychiatric medications (names, dosages, length of time, purpose of medication, results, and side effects)? Please list all medications separately:

Psychiatric medications were prescribed by: ___Psychiatrist ___Primary Care Provider ___Nurse Practitioner

___Other (specify): _____

DRUG AND ALCOHOL HISTORY (If Applicable)

Cigarettes/Tobacco

Does the patient currently smoke or chew? ___YES ___NO If yes: Number of years: ____ Number of packs a day: ____

How long has it been since the patient's last cigarette? _____

If the patient does not smoke or chew, have they in the past? ___YES ___NO

Caffeine

Does the patient drink coffee or other caffeinated beverages? ___YES ___NO

Type of beverage: _____

Number of cups of 8oz. servings per day: _____

Alcohol

Does the patient drink alcohol currently or have they within the past year? ___YES ___NO

How many times per week? _____ Type of beverage: _____

Average amount consumed each week? _____ How long has the patient been drinking? _____

If not currently drinking, have they consumed alcohol in the past? ___YES ___NO

Type of beverage: _____ How much and for how long? _____

How long since last use at this level? _____

Current Illicit Drug History

Does the patient use drugs or illicit substances currently/past year? ___YES ___NO

Type: _____

How Much/How Often/How Long? _____

Past Illicit Drug History

Has the patient used drugs in the past? ___YES ___NO

Type: _____

How Much/How Often/How Long? _____

Does the patient participate in any programs for remaining clean and sober? ___YES ___NO

If yes, please identify programs: _____

Is the patient currently involved in a recovery program? ___YES ___NO

If yes, please describe: _____

_____

Risk Assessment

Does the patient have thoughts of self-harm? ___YES ___NO
Does the patient have a plan for how they would self-harm? ___YES ___NO
Has the patient attempted self-harm in the past? ___YES ___NO If yes, how? _____
Have any relatives committed suicide? ___YES ___NO
Does the patient have thoughts of harming someone else? ___YES ___NO
Has the patient assaulted or threatened anyone recently? ___YES ___NO
Has the patient ever been in trouble because of their temper/violence? ___YES ___NO
Does drinking/drugging ever lead them to become violent? ___YES ___NO
Do you own a gun or a lethal weapon? ___YES ___NO
Has the patient ever considered/planned to harm themself or others with this gun or other lethal weapon? ___YES ___NO

MEDICAL HISTORY

Has the patient ever had or currently has any of the following? Check all that apply:

	Accident Prone		Frequent Urinary Infections		Movement Disorder
	Allergies		Gallbladder Problems		Muscle Soreness
	Arthritis		Head Injury		Nose Bleeds
	Asthma		Headache		Orthopedic/Osteo
	Back Problems		Hearing/Ear Problems		Other Neurological Disorders
	Black Outs		Hemorrhoids		Ovarian/Prostrate
	Blood in Stool		Hepatitis		Pneumonia
	Broken Bones/Fractures		Hernia		Seizures
	Cancer		High Blood Pressure		Shortness of Breath
	Chest Pain/Pressure/Tightening		High Cholesterol		Skin Disorders
	Depression		High Triglycerides		STDs
	Diabetes		Hypertension		Stroke
	Dietary Issues		Injuries/ Broken Bones		TB/Lung Disorder
	Difficulty Hearing		Irregular Sleep		Thyroid Problems
	Digestive Problems		Kidney Problems		Tics (motor or verbal)
	Dizzy Spells/Fainting		Liver Problems		Ulcers
	Eczema		Memory Loss		Vision/Eye Health

Has the patient experienced any other physical conditions or difficulties not listed above, please share them in the space provided below:

History of head trauma (please specify):

Past surgeries or hospitalizations (please specify with dates):

Allergies

Allergies to medications (please specify):

Allergies (e.g., itchiness or hives) to specific kinds of soaps/laundry detergents/perfumes:

Allergies to food:

Current Medications and Dosages (please list all names, dosages, lengths of time, purposes of medication, results, and side effects):

Prescription:

Over-the-Counter:

Herbal:

Type of Birth Control (if applicable):

Name of your Primary Care Physician_____

List any other physicians treating the patient _____

List any accidents the patient has ever had:

_____

_____

Please give a general history of previous prescription medications the patient has taken. Understanding that you may not recall each type of antibiotic or its purpose, etc…

_____

_____

Has the patient worked with any alternative medicine programs such as: acupuncture, herbal, alternative healers? If so, please give an overview of why, the effectiveness of the treatment, and approximate dates.

_____

Family Background and Childhood History

Was the patient adopted ___ YES ___NO Where did the patient grow up_____

List siblings and their ages: _____

Are their parents divorced? ___YES ___NO If so, how old was the patient when they divorced? _____

If parents are divorced, who does the patient live with? _____

Has the patient left home? _____

Has anyone in the immediate family died? _____

Who currently lives with the patient? _____

Any other changes in the family or other stressful occurrences? _____

Reproductive History (If Applicable)

Is the patient pregnant? ___YES ___NO Is the patient breast-feeding? ___YES ___NO

Number of previous pregnancies: ____
Number of previous live births: ____
Number of living children: ____

Milestones

Length of Pregnancy_____ Birth Weight_____

Planned or unplanned pregnancy_____

Was the pregnancy complicated or involved with drugs or alcohol? _____

Nature of delivery ____Natural ____Caesarian ____Breech

Condition of child at time of birth_____

Please give age your child _____Crawled _____Walked _____Talked _____Toilet Trained

Did the patient have friends as a child? ____Many ____Few ____None

Does the patient have friends currently? ____Many ____Few ____None

Trauma History

Does the patient have a history of being abused emotionally, sexually, physically, or by neglect? ___YES ___ NO

Please describe when, where, and by whom_____

_____

_____

Sex/Gender Identity

Does the patient identify as: ___ Male ___ Female ___ Transgender ___ Other _____

Please list any questions, concerns, or comments you have, if any, about the patient's gender or gender identity (sense of femaleness/maleness). _____

_____

_____

Education History

What district/county does the patient attend school now? _____

Public or Private _____

What grade? _____

What extracurricular activities is the patient involved in? _____

Legal

Has the patient ever been arrested? ___YES ___NO

If yes, for what? _____

Does the patient have any pending legal issues? ___YES ___NO

Spiritual Life

Does the patient belong to a particular religion or spiritual group? ___YES ___NO

If yes, what is the level of their involvement? _____

Does the patient find their involvement helpful during this illness, or does the involvement make things more difficult and stressful for them? _____

Cultural

Languages Spoken: _____

List any cultural values, beliefs, or practices that should be considered in the patient's treatment:

_____

_____

_____

PHARMACY OF CHOICE (For e-prescriptions)

Pharmacy Name: _____ Store #: _____

Address: _____

_____

Phone #: _____

FAMILY HISTORY:
IN THE TWO SECTIONS BELOW PLEASE CHECK AS APPLICABLE TO YOUR INDIVIDUAL FAMILY HISTORY
Please pay special attention to anyone with symptoms similar to your presenting symptoms

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother's	Siblings	Children	Maternal Relatives	Paternal Relatives
High Blood Pressure										
Epilepsy										
Seizures										
Cancer										
Heart Attack										
Stroke										
Diabetes										
Asthma										
Dizzy Spells/Fainting										
Movement Disorders										
Tics (motor or verbal)										
Other Neurological Disorders										

Family History of Mental Illness/Alcoholism/Drug Abuse
Please pay special attention to anyone with symptoms similar to your presenting symptoms, not necessarily diagnosed

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Maternal Relatives	Paternal Relatives
Depression										
Bipolar Disorder/Manic Depression										
Schizophrenia										
ADHD										
Concentration Problems										
Hyperactivity										
Anger Outbursts										
Periods of Severe Agitation										
Nervous Breakdowns										
Anxiety										
Panic Attacks										
Phobias										
Obsessive Thinking/Worrying										
Compulsions										
Attempted Suicides										
Completed Suicides										
Alcoholism										
Drug Abuse										
History of past/present abuse (as abuser)										
History of past/present abuse (as victim)										
Other Family History (Please Specify)										