

House Psychiatric Clinic - Child & Adolescent Intake

Child's Name:

Child's date of birth:

What is the child's age?

Child Behaviors - current or past (check all that apply)

- | | |
|---------------------------|---------------------------|
| Acts strangely. | Attempts weight loss. |
| Seeks attention. | Argues with adults. |
| Avoids homework. | Blames others. |
| Bullies others. | Doesn't accept affection. |
| Doesn't listen to others. | Doesn't offer affection. |
| Checks (as a ritual). | Counts (as a ritual). |
| Exercises excessively. | Hoards objects. |
| Starts fights. | Lacks conscious. |
| Lacks follow through. | Lacks imaginative play. |
| Lies. | Misses curfews. |
| Runs away. | Sets fires. |
| Shows inflexibility. | Shows narrow interests. |
| Shows perfectionism. | Startles easily. |
| Steals. | Takes risks. |
| Tortures animals. | Vandalizes. |
| Washes hands repeatedly. | None of these apply. |

Fears - current or past (check all that apply):

- | | |
|--------------------------|-------------------------------|
| Fears abandonment. | Fears being away from family. |
| Fears crowds. | Fears dying. |
| Fears embarrassment. | Fears gaining weight. |
| Fears losing loved ones. | None of the above apply. |

Feelings - current or past (check all that apply).

Agitated.	Angry.
Anxious.	Cocky.
Depressed.	Indecisive.
Invincible.	Helpless.
Hopeless.	Lack of self-worth.
Moody.	Unstable.
None of the above apply.	

Interpersonal - current or past (check all that apply)

Doesn't reciprocate emotions.	Has poor social skills.
Is easily influenced.	Lacks any concern for praise.
Lacks peer relationships.	Shows poor eye contact.
Shows unusual speech.	None of the above apply.

Thoughts - current or past (check all that apply)

Forgets things.
Has fixed false beliefs that are untrue.
Thoughts are disorganized or hard to follow.
Has intrusive thoughts - can't get a thought out of his/her mind.
Thinks people are out to harm him/her. Thoughts of paranoia.
Shows thoughts that are going too fast.
Hears voices that are not there.
Obsesses over symmetry.
Sees things that are not there.
Thinks about death/suicide.
Worries about health.
Smells things that are not there.
None of these apply.

Physical symptoms - current or past (Check all that apply)

Chills or hot flashes.	Muscle tension.	Nauseated.
Sleepy in daytime.	Too energetic.	Too tired.
Appetite changes.	Weight changes.	Need little sleep.
Sleep too much.	Sweats.	Trembles.
None of these apply.		

Attention/Hyperactivity/Impulsivity

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Fails to give close attention to details or makes careless mistakes.					
Difficulty sustaining attention in task or play.					
Doesn't seem to listen when spoken to directly.					
Often does not follow through on directions and fails to finish.					
Difficulty organizing tasks or activities.					
Reluctant to engage in tasks or activities that require sustained mental effort.					
Often easily distracted by environment.					
Often fidgets with hands or squirms in seat.					
Often leaves seat in classroom or in other situations in which remaining seated is expected.					
Often runs about or climbs excessively.					
Often has difficulty playing or engaging in fun activities quietly.					
Is often on the go or driven by a motor.					
Often talks excessively.					
Often blurts out answers before questions have been completed.					
Often has difficulty awaiting turn.					

Attention/Hyperactivity/Impulsivity (Continued)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Is often forgetful in daily activities.					
Often interrupts or intrudes on others (butts into conversations).					

Is the child allergic to any medications?

Yes

No known drug allergies.

If yes, what medications caused the allergy and what was the response?

What medications is the child taking?

What psychiatric medications has the child taken? If known, please indicate dose and reason medication was discontinued (eg. ineffective, side effect, cost).

What mental health providers has patient seen?

Has child ever been in a psychiatric facility or rehab? If so, where and when?

Has the child ever attempted suicide?

Yes.

No.

I don't know.

If yes to above, please provide details of what happened.

Has child ever cut on self, burned self or down other bodily harm that was not suicidal in nature?

Yes.

No.

I don't know.

Please indicate if the child has any of the following:

No medical issues.

Asthma.

Diabetes.

Glaucoma.

Head Aches.

Head Trauma.

Heart Problems.

Kidney Problems.

Liver Problems.

Cancer.

Please list any medical conditions not covered above:

Please list any surgeries:

Please list any psychiatric issues that run in the family:

Anxiety.

Bipolar Disorder.

Attention deficits.

Attempted Suicide.

Completed Suicide.

Depression.

Panic Attacks.

Schizophrenia.

Drug use.

None of the above.

Are there any medical issues that run in the family? Is so, please list condition and relationship.

Did the individual's mother use any alcohol during pregnancy?

Yes.

No.

Did the individual's mother use any illicit drugs (including marijuana) during pregnancy?

Yes.

No.

Did the individual's mother use tobacco during pregnancy?

Yes.

No.

Did the individual's mother use medications during pregnancy?

Yes.

No.

If yes to above, please list medications during pregnancy.

Were there any complications during pregnancy? If so, please explain.

Was the child born (check all that apply)

Early.

Late.

On time.

Natural delivery.

C-Section.

What was child's weight at birth?

At what age was child walking?

At what age was child talking?

At what age was child potty trained?

Who are the main adults who have raised the child?

Is the child currently in school?

Yes.

No.

If yes, what school does child attend and what grade is he/she in?

Has the child had any disciplinary problems at school? If so, please described.

Has the individual or his/her siblings ever been the focus of an investigation by Child Protective Services (CPS)? If so, please described the details.

Has the child ever been physically abused? If so, please provide the details.

Has the child ever been emotionally abused? If so, please provide the details.

Has the child ever been sexually abused? If so, please provide the details.

Has the child ever had basic needs neglected? If so, please provide the details.

Has the child ever used any of the following:

Alcohol.

Tobacco.

Marijuana.

Methamphetamine

Other drugs.

None. No drug use.

Has the child ever been arrested? If so, provide the details.

Please read and type name in space below if agree to the following: "I have filled out the preceding information as accurately as possible. Since the information concerns a minor, I understand that I can only sign this form if I am an actual guardian."

Date signed.