



Pediatric Psychiatric Intake Form – Patient/Parent

GENERAL INFORMATION

Patient Name: _____ Date of Birth: _____
Person completing form: _____ Relation to patient: _____

PLEASE DESCRIBE THE REASON FOR VISIT AND/OR CURRENT CONCERNS:

RISK ASSESSMENT

Has your child ever attempted suicide? Yes No

Has your child ever harmed themselves by cutting, burning, etc.? Yes No

Has your child recently engaged in risk-taking behavior? *(Check all that apply)*

Alcohol/drug use Gang involvement Unprotected sex Drug dealing Shoplifting

Trading sex for money, drugs or possessions Reckless driving Carrying/using a weapon

Other: _____

Do you feel that you live in a safe place? Yes No

Are there guns in your home? Yes No

If yes, are the guns locked up? Yes No

Has your child ever witnessed violence in the home? Yes No

LEGAL INVOLVEMENT

Has your child ever been on probation? Yes No

Has your child ever received child protective services (CPS)? Yes No

Has your child had any other involvement with the legal system? Yes No

If yes to any of the above, please explain:

MENTAL HEALTH HISTORY *Please check all current and previous mental health care*

Provide details (location, dates, provider's name, etc.)

Inpatient Hospitalization Details: _____

Partial Hospitalization (PHP) Details: _____

Intensive Outpatient (IOP) Details: _____

Residential Treatment (IRTS) Details: _____

Psychiatric Care Details: _____

Therapy Details: _____

Substance Abuse Treatment Details: _____

Case Management Details: _____

In-home Skills/Family Therapy Details: _____

Other:

Details: _____

ALL CURRENT AND PAST MEDICATIONS TRIED

Antidepressants

- Prozac (fluoxetine)
- Zoloft (sertraline)
- Lexapro (escitalopram)
- Celexa (citalopram)
- Luvox (fluvoxamine)
- Paxil (paroxetine)
- Wellbutrin (bupropion)
- Effexor (venlafaxine)
- Pristiq (desvenlafaxine)
- Cymbalta (duloxetine)
- Viibryd (vilazodone)
- Fetzima (levomilnacipran)
- Trintellix (vortioxetine)
- Elavil (amitriptyline)
- Pamelor (nortriptyline)
- Tofranil (imipramine)
- Norpramin (desipramine)
- Anafranil (clomipramine)
- Emsam (selegiline)

Anti-Anxiety / Anti-Hypertensives

- Catapres (clonidine)
- Kapvay (clonidine ER)
- Tenex (guanfacine)
- Intuniv (guanfacine ER)
- Buspar (buspirone)
- Vistaril (hydroxyzine pamoate)
- Atarax (hydroxyzine hcl)
- Inderal (propranolol)
- Tenormin (atenolol)

Benzodiazepines

- Xanax (alprazolam)
- Ativan (lorazepam)
- Klonopin (clonazepam)
- Valium (diazepam)
- Restoril (temazepam)
- Librium (chlordiazepoxide)

Stimulants

- Adderall (dextroamphetamine/amphetamine)
- Vyvanse (lisdexamfetamine)

- Dexedrine (dextroamphetamine)
- Adzenys (amphetamine ODT or liquid)
- Concerta (methylphenidate ER)
- Ritalin LA (methylphenidate LA)
- Metadate (methylphenidate CD)
- Daytrana (methylphenidate patch)
- Quillivant (methylphenidate chew or liquid)
- Focalin (dexmethylphenidate)
- Strattera (atomoxetine)
- Provigil (modafinil)
- Nuvigil (armodafinil)

Mood Stabilizers

- Lamictal (lamotrigine)
- Trileptal (oxcarbazepine)
- Lithobid/Eskalith (lithium)
- Depakote (valproic acid/divalproex)
- Tegretol (carbamazepine)
- Topamax (topiramate)
- Neurontin (gabapentin)

Antipsychotics / Neuroleptics

- Risperdal (risperidone)
- Abilify (aripiprazole)
- Rexulti (brexpiprazole)
- Seroquel (quetiapine)
- Zyprexa (olanzapine)
- Invega (paliperidone)
- Latuda (lurasidone)
- Geodon (ziprasidone)
- Vraylar (cariprazine)
- Saphris (asenapine)
- Haldol (haloperidol)
- Clozaril (clozapine)
- Thorazine (chlorpromazine)
- Fanapt (iloperidone)

Sleep Aids / Sedatives

- melatonin
- Unisom (doxylamine)
- Benadryl (diphenhydramine)
- Desyrel (trazodone)

- | | |
|--|--|
| <input type="checkbox"/> Remeron (mirtazapine) | <input type="checkbox"/> Sonata (zaleplon) |
| <input type="checkbox"/> Ambien (zolpidem) | <input type="checkbox"/> Silenor (doxepin) |
| <input type="checkbox"/> Lunesta (eszopiclone) | <input type="checkbox"/> Rozerem (ramelteon) |

YOUR CHILD'S DEVELOPMENT

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

How long was the pregnancy? _____ Weeks Unknown

Concerns or complications that occurred during pregnancy (*check all that apply*):

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> No (or poor) prenatal care | <input type="checkbox"/> Preterm labor | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Preeclampsia | <input type="checkbox"/> Serious infection or illness | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Significant stress or trauma | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other _____ | |

- | | | | |
|---|----------------------------------|-----------------------------------|----------------------------------|
| -How was your child delivered? | <input type="checkbox"/> Vaginal | <input type="checkbox"/> Cesarean | <input type="checkbox"/> Unknown |
| -Was your child's delivery induced? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| -Was your child's delivery an emergency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| -Did your child come home within 2 days of delivery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| -Were there any complications during labor or the delivery of your child? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |

If yes to any of the above, please explain:

Concerns during your child's development (*check all that apply*):

- | | | |
|---|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Social skills/interacting with others | <input type="checkbox"/> Calming | <input type="checkbox"/> Speech |
| <input type="checkbox"/> Play | <input type="checkbox"/> Tantrums | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Activity level | <input type="checkbox"/> Language | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Gross motor skills (running, moving, crawling) | | |
| <input type="checkbox"/> Fine motor skills (eating, writing, buttoning a shirt) | | |

Childhood developmental delays (*check all that apply*):

- | | |
|--|---|
| <input type="checkbox"/> Speech | <input type="checkbox"/> Toilet training |
| <input type="checkbox"/> Sitting, crawling, or walking | <input type="checkbox"/> Sleeping through the night |

Other: _____

FAMILY MENTAL HEALTH HISTORY

- | | |
|---|------------|
| <input type="checkbox"/> Suicide attempt | Who: _____ |
| <input type="checkbox"/> Death by suicide | Who: _____ |
| <input type="checkbox"/> Schizophrenia | Who: _____ |
| <input type="checkbox"/> Bipolar disorder | Who: _____ |
| <input type="checkbox"/> Depression | Who: _____ |
| <input type="checkbox"/> Anxiety | Who: _____ |
| <input type="checkbox"/> ADHD | Who: _____ |
| <input type="checkbox"/> Autism Spectrum Disorder | Who: _____ |
| <input type="checkbox"/> OCD | Who: _____ |
| <input type="checkbox"/> Personality Disorder | Who: _____ |
| <input type="checkbox"/> Eating Disorder | Who: _____ |
| <input type="checkbox"/> Alcoholism | Who: _____ |
| <input type="checkbox"/> Drug addiction | Who: _____ |

Other: _____

SOCIAL HISTORY

Who does your child live with?

(Check all that apply)

- Father
- Mother
- Step parent(s)
- Sibling(s)
- Grandparent(s)
- Foster care
- Other: _____

Describe your child's biological parents' current relationship *(Check all that apply)*

- Never married, living together
- Never married, living apart
- Married
- Separated
- Divorced
- Biological mother remarried
- Biological father remarried
- Widowed
- Other: _____

Please describe any court-ordered custody arrangements regarding your child:

SUPPORT SYSTEM

Who is most supportive to your child? *(Check all that apply)*

- Father
- Mother
- Step parent(s)
- Sibling(s)
- Grandparent(s)
- Teacher(s)
- Friend(s)
- Pastor/Spiritual Leader
- Other: _____

EDUCATION HISTORY

Current School: _____ Grade: _____

Has your child experienced any difficulties with the following? (*check all that apply*)

- Reading
- Writing
- Math
- Other: _____

- Does your child have an Individualized Education Plan (IEP)? Yes No
- Does your child have a 504 plan? Yes No

EMPLOYMENT

-What is your child's employment status? (*Check one*)

- Employed full-time
- Employed part-time
- Not employed and NOT seeking employment
- Not employed and seeking employment

If employed, where does your child work? _____

-What is your employment status? (*Check one*)

- Employed full-time
- Employed part-time
- Not employed and NOT seeking employment
- Not employed and seeking employment

If employed, what is your occupation? _____

-What is the employment status of your child's other parent/guardian? (*Check one*)

- Employed full-time
- Employed part-time
- Not employed and NOT seeking employment
- Not employed and seeking employment

If employed, what is his/her occupation? _____

STRENGTHS & INTERESTS

List three of your child's strengths, special gifts and/or talents:

1. _____
2. _____
3. _____

List three activities or hobbies that your child enjoys:

1. _____
2. _____
3. _____

MEDICAL CONCERNS

Head

- Concussion
- Head injury
- Headaches
- Migraines
- Traumatic brain injury
- Other: _____

Gastrointestinal

- Heartburn/reflux
- Nausea
- Constipation
- Diarrhea
- Abdominal pain
- Black or bloody bowel movement
- Other: _____

Constitutional

- Weight gain
- Sleep difficulties
- Poor appetite
- Weight loss
- Fatigue
- Fever
- Other: _____

Eyes

- Needs glasses/contacts
- Eye pain
- Double vision
- Decreased vision
- Other: _____

Genitourinary

- Increased urinary frequency
- Bedwetting
- Blood in urine
- Pain/discomfort
- Abnormal discharge
- Bladder leakage
- Menstrual issues
- Other: _____

Sensory Concerns

- Sound/noise
- Touch/tactile
- Oral/textures
- Clothing/tactile
- Scent/smell
- Other: _____

Ears, Nose, Throat

- Difficulty hearing
- Ringing in ears
- Vertigo
- Difficulty swallowing
- Pain
- Other: _____

Musculoskeletal

- Joint pain/swelling
- Stiffness
- Muscle pain
- Back pain
- Other: _____

Endocrine

- Unexplained wght loss
- Unexplained wght gain
- Hot/cold intolerance
- Diabetes
- Thyroid issues
- Other: _____

Cardiovascular

- Murmur
- Chest pain
- Palpitations
- Dizziness
- Fainting spells
- Shortness of breath
- Difficulty lying flat
- Swelling ankles
- Other: _____

Neurological

- Loss of strength
- Numbness
- Headaches
- Tremors
- Memory Loss
- Seizures
- Tourette's syndrome
- Other: _____

Respiratory

- Cough
- Pain
- Shortness of breath
- Use of inhaler
- Use of oxygen
- Other: _____

Skin

- Hair loss
- Rash/hives
- Lesions/sores
- Itching
- Easy bruising
- Other: _____