Walston Health Services

6165 Fuller Court, Suite2 Alexandria, VA 22310
(703) 924-9810 Fax: (703) 924-7044 walstonhealthservices@gmail.com

Child & Adolescent Psychiatry Intake Form

Dear Parents/Guardian, the information you provide by completing this form will help your provider in identifying your child's needs. Please use the back of these forms if more room is needed.

Child's Name:____Date: __________Age:_________________

Child's Address: ____

This form was completed by: __________________________________Date: ______________________________

Who has legal custody of this patient? (ie who can legally make medical decisions about the child's care)

____

Who referred you the clinic? ____

Family Demographics

Father or Male Caretaker's Information

Name: _______________________________________Age: __________Occupation:__________________________

Living in home? Yes☐ No☐ If not, address: ____

Relationship: Biological Father☐ Adoptive Father☐ Step-Father☐ Other☐

Marital Status:____Date Married:_________________________

(Voluntary) Cultural background:________________________________Religion:______________________________

Telephone (home):_____________________(work):_______________________(cell): _______________________

Email____

Mother or Female Caretaker's Information

Name: _______________________________________Age: __________Occupation:__________________________

Living in home? Yes☐ No☐ If not, address: ____

Relationship: Biological Father☐ Adoptive Father☐ Step-Father☐ Other☐

Marital Status:____Date Married:_________________________

(Voluntary) Cultural background:________________________________Religion:______________________________

Telephone (home):_____________________(work):_______________________(cell): _______________________

Email____

Main Concerns / Reason for Referral

A. Please list the primary concerns you have about your child: ____
____
____
____

B. How long have you had these concerns? ____
____

C. What are your goals of treatment for your child? ____
____
____
____

D. Does your child have problems with activities of daily living (dressing, feeding, grooming, bathing)? _________
____
____
____
____

E. Please indicate ☒ if child has exhibited any of the following behaviors:

1.	Has trouble hearing	❑	❑
2.	Is overly sensitive to sounds	❑	❑
3.	Has visual problems	❑	❑
4.	Tilts his/her head to look at items	❑	❑
5.	Has daytime toilet accidents	❑	❑
6.	Repetitive flapping or spinning	❑	❑
7.	Has poor eye contact	❑	❑
8.	Doesn’t play with other children	❑	❑
9.	Is preoccupied with interest	❑	❑
10.	Can’t tolerate a change in routine	❑	❑

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11. Is very sensitive to textures	❑	❑
12. Stares into space as if in a trance	❑	❑
13. Is easily frustrated	❑	❑
14. Has frequent tantrums	❑	❑
15. Rarely smiles, giggles, laughs	❑	❑
16. Has problems sleeping	❑	❑
17. Has unusual fears/nightmares	❑	❑
18. Sleepwalks	❑	❑
19. Eats things that aren't food	❑	❑
20. Goes on diets	❑	❑
21. Is aggressive to others	❑	❑
22. Is cruel to animals	❑	❑
23. Running away from home	❑	❑
24. Shoplifting / Stealing	❑	❑
25. Frequent lying	❑	❑
26. Depression / Sadness	❑	❑
27. Isolation / withdrawal	❑	❑
28. Irritability / anger	❑	❑
29. Rapid / intense mood swings	❑	❑
30. Explosive outbursts	❑	❑
31. Significant weight change	❑	❑
32. Appetite change	❑	❑
33. Excessive worries / anxiety	❑	❑
34. Declining school grades	❑	❑
35. Refusal to attend school	❑	❑
36. Paranoid thinking	❑	❑
37. Sudden recurrent motor movements (blinking, shoulder shrugging, head jerking)	❑	❑
38. Sudden recurrent vocalizations (chirping, sniffing, coughing)	❑	❑
39. Sexually Inappropriate behavior	❑	❑
40. Has "melt downs"	❑	❑
41. Has lost interest in doing fun activities	❑	❑

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Child's Past Psychiatric History

A. Please list your child's past psychiatric or psychological evaluations and/or therapy or counseling provided by school, physicians, clinics, counselors, or psychologist (include phone# if possible).
-Please note the **Date, Location, and Results** of the testing and/or therapy.
-**Please Bring Evaluations to First Appointment**

____

____

____

____

B. Has your child ever been hospitalized for psychiatric reasons? ❑Yes ❑No. If yes, please explain ___________

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____

____

C. Has your child ever attempted suicide? ❑Yes ❑No. If yes, please explain______________________________

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D. Has your child ever engaged in self-injurious behavior? ❑Yes ❑No. Please explain____________________

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____

E. Has your child ever been abused? ❑None ❑Physical ❑Sexual ❑Emotional

Has Child Protective Services and/or Family Advocacy Program ever been involved? ❑Yes ❑No.

If yes, please explain____

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F. Has your child ever drunk alcohol, used marijuana, abused prescription pain killers, or used other recreational drugs? ❑Yes ❑No. Please explain______________________________________

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G. Has your child ever misused or taken more medication than prescribed? ❑Yes ❑No. Please explain

H. Are there any substances you fear that your child may be using abusing? ❑Yes ❑No. Please explain

I. Has your child ever used medication that was prescribed for someone else? ❑Yes ❑No. Please explain

J. Has your child ever received counseling for substance abuse? ❑Yes ❑No. Please explain

K. Please list any past psychiatric medications your child has taken:

Medication	For how long?	Reason for taking medication

L. What psychiatric medication is your child currently taking?

M. Are there any side effects from the medication/s that your child is experiencing?

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Child's Medical History

A. Child's physician's name: ____

Date of last comprehensive physical exam: ______________________________________

Has child seen any medical specialists such as cardiologist or neurologists? ❑Yes ❑No. Please explain _____

____

____

____

B. Has your child been hospitalized for medical reasons? ❑Yes ❑No. Please explain ______________

____

____

C. Has your child ever had any surgeries? ❑Yes ❑No. If so, why, when, where? ________________

____

____

____

D. List any seizures, head injury, loss of consciousness/concussion, or neurological evaluations __________

____

____

E. Has your child ever experienced a physical trauma or injuries? ❑Yes ❑No. If yes, please explain ________

____

____

F. Does your child have drug, food, or environmental allergies? ❑Yes ❑No. If so, please describe. ________

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____

____

G. Please indicate the child's current level of pain:

No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Extreme Pain

Comments:____

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____

H. Please indicate ☒ if your child has had any of the following medical illnesses or problems.

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Frequent ear infections	❑	Shortness of breath	❑
Hearing problems	❑	Fainting	❑
Eye problems	❑	Heart defect	❑
Swallowing problems	❑	Prior EKG	❑
Thyroid disease	❑	Encephalitis	❑
Headaches	❑	Meningitis	❑
Ear Tubes	❑	Low blood count/anemia	❑
Cardiac arrhythmias	❑	Accidents	❑
Heart murmurs	❑	Broken bones	❑

Other:____

____

I. List any medication(s) your child is currently taking? Include over-the-counter medication, herbal supplements, and diet pills:

Medication	For how long?	Reason for taking medication

J. To the best of your knowledge is your child sexually active? ❑Yes ❑No. Please explain ________________

____

If child is a female, has menstrual cycle begun? ❑Yes ❑No. If yes, age of onset? ____________________

K. Nutritional History ____

- Any problems with chewing, swallowing, chocking, feeding? ❑Yes ❑No ____________________
- Any food allergies/intolerance? ❑Yes ❑No ____
- Any weight gain or weight loss of 10 lbs in the past 6 months? ❑Yes ❑No __________________
- Any concerns that your child may have an eating disorder? Vomiting? Excessive dieting? Excessive exercising? Low caloric intake? ❑Yes ❑No ____
- Would you like to discuss nutritional issues with a dietician? ❑Yes ❑No____________________

Pregnancy and Birth History

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A. Prenatal History – (*Questions refer to the pregnancy of the child who is being evaluated.*)

Please recall the following the best you can:

	Yes	No	Comment
Was this child a planned pregnancy?	❑	❑	______________________
Did mother …….			
Take any medication during pregnancy?	❑	❑	______________________
Smoke cigarettes during the pregnancy?	❑	❑	______________________
Drink alcohol during the pregnancy?	❑	❑	______________________
Use any other drugs during pregnancy?	❑	❑	______________________

Were there any complications during the pregnancy? ______________________________________

____

____

B. Labor History:

Was the baby full term? ❑Yes ❑No. If not, how many weeks old at birth? ________________

Were there any problems with delivery? ❑Yes ❑No ______________________________

Was delivery induced or spontaneous? ______________________________________

Were forceps used? ____

Nuchal cord? ❑Yes ❑No ____

Meconium staining? ❑Yes ❑No ______________________________________

What was the birth weight of the child? ______________________________________

Length of stay in the hospital: Mother:_____________days Child: ____________days

C. Infant's Condition at Birth: ____

Any problems shortly after birth? ____

____

Developmental and Skill Profile

A. Between the ages of 0 and 2-years-old, was your child:

- Extremely sensitive to slight changes in touch, sound level, lighting, etc? ❑Yes ❑No
- Unable to develop a regular sleeping pattern? ❑Yes ❑No
- Impossible or very difficult to soothe or calm self when distressed/upset? ❑Yes ❑No

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- Unable to separate from parents without extreme distress? ❑Yes ❑No
- Unable to show affection? ❑Yes ❑No

B. Check the boxes as appropriate to describe developmental milestones

Milestone	Age achieved (If known)	Early	On time	Late	Don't Know
Walked alone		❑	❑	❑	❑
Said first words		❑	❑	❑	❑
Daytime toileting		❑	❑	❑	❑
Bladder training		❑	❑	❑	❑
Bowel training		❑	❑	❑	❑
Tied shoelace		❑	❑	❑	❑
Wrote name		❑	❑	❑	❑

C. What are your child's strengths? ____

____

D. Please list your child's leisure time activities (i.e. sports, clubs, internet use, social networking sites) : ________

____

____

E. Please list any problems with use of TV, internet, or cell phone: ______________________

____

F. What is your family's religious or spiritual affiliation? ______________________________

Does your child have religious, spiritual, or cultural practices your provider needs to be aware of during treatment? ____

Educational History

A. Name of current school: ______________________Location: ______________

Teacher or Counselor's name:______________Grade:_______Phone:__________

B. How many schools has your child attended? ______________________________

C. What are the average grades your child receives? __________________________

- Has child repeated a grade or subject? ❑Yes ❑No What grade or subject? __________
- Please list any subjects your child is currently failing, if any: ____________________

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D. Has child been suspended or expelled? ❑Yes ❑No If "Yes," please explain: ____________________________

____

E. Has your child received any special education services (IEP) or other academic support like 504 plan?
❑Yes ❑No ____
If so, PLEASE BRING THE IEP TO YOUR FIRST APPOINTMENT and briefly describe below.
Any history of Occupational Therapy, Speech Therapy, or Counseling in the school setting? ______________

____

____

F. Please indicate any problems your child has in school:

Reading	❑	Spelling	❑
Writing	❑	Math	❑
Does not get along with teacher	❑	Does not get along with students	❑

Family Social & Medical History

A. Does this child have other parent(s) and/or stepparent(s)? ❑Yes ❑No
If yes, please provide the following information:

Name | Relationship to this child | Location (city, state)

____

____

____

____

B. Please list everyone living in household:

Names (last, first) | Age | Relationship

____

____

____

____

____

____

C. If the patient has any other siblings not living with him/her, please list them below.

Name (last, first) | Age | Relationship

____

____

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____

____

D. Who is the child's primary care giver? Name: ______________________________

E. How many hours per day is your child in a child-care setting? ______________________

F. If child is not living with biological parents list why: ______________________________

____

G. Please indicate ☒ on the chart below anyone in child's biological family who has a history of any of the problems listed below. (If child is not living with biological parent, please include health information on biological parents if known):

	Child's Father	Father's Family	Child's Mother	Mother's Family	Child's Siblings
Attention Difficulties and/or Hyperactivity	❑	❑	❑	❑	❑
Learning Difficulties	❑	❑	❑	❑	❑
Mental retardation	❑	❑	❑	❑	❑
Autism	❑	❑	❑	❑	❑
Problems with alcohol and/or drugs	❑	❑	❑	❑	❑
Seizures/convulsions	❑	❑	❑	❑	❑
Cardiac defects/arrhythmias	❑	❑	❑	❑	❑
Tourette's syndrome	❑	❑	❑	❑	❑
Eating Disorder	❑	❑	❑	❑	❑
Nervousness or anxiety	❑	❑	❑	❑	❑
Schizophrenia	❑	❑	❑	❑	❑
Bipolar (Manic/Depressive) Disorder	❑	❑	❑	❑	❑
Nervous Breakdown	❑	❑	❑	❑	❑
Mental Health Hospitalization	❑	❑	❑	❑	❑
Depression/Other mental health problems	❑	❑	❑	❑	❑
Self-mutilation	❑	❑	❑	❑	❑
Suicide	❑	❑	❑	❑	❑
Sudden Death	❑	❑	❑	❑	❑
Legal Problems (Incarceration)	❑	❑	❑	❑	❑

Other: ____

____

____

H. Please tell us of any significant stressors your family had experienced in the past year.

Death	❑	Deployment	❑
Divorce or separation	❑	Work stressors	❑
Child or Spouse abuse	❑	Legal problems	❑

Other stressors: ____

____

____

I. To what extent do you and your spouse generally agree on how to discipline your child?

Never agree ① ② ③ ④ ⑤ *Always agree*

J. What methods of discipline do you typically use?

Time-out	❑	Ground	❑
Take privileges (TV, games, allowance)	❑	Yell	❑
Give rewards for doing well	❑	Spank	❑
"1-2-3 Magic" or other behavior course	❑		

Other methods used: ____

____

Risk Assessment

A. Are there any firearms in any homes where your child resides? ❑Yes ❑No

B. Is there any history of domestic violence in the home? ❑Yes ❑No

If yes, has family ever been referred to CPS or FAP? ❑Yes ❑No

C. Does your child have a history of homicidal (harm to others) thoughts or behaviors? ❑Yes ❑No

D. Does your child have current homicidal (harm to others) thoughts or behaviors? ❑Yes ❑No

E. Does your child wear seat belt? ❑Yes ❑No

F. Does your child have history of suicidal thoughts or behaviors? ❑Yes ❑No

G. Does your child have current suicidal thoughts or behaviors? ❑Yes ❑No

H. Do you have other safety concerns at this time? ❑Yes ❑No

If yes, please explain: ____

____

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