CHILD AND ADOLESCENT MENTAL HEALTH FORM

Instructions:

1. Please fill out this questionnaire completely and accurately as possible. Completion of this form is required for an intake to be scheduled, and a new patient cannot be seen without it.
2. If the guardian is not a biological parent, legal custody documentation MUST be brought to our office before the child can be seen. NO EXCEPTIONS.
3. Any information that is not known should be answered with "unknown" or "not applicable". Identical information does not need to be repeated (addresses, etc.).
4. Any additional information may be written on the back of the form.
5. Please bring any reports from teachers and/or school testing (IEP/504 plan reports, etc.) to the first appointment.
6. Please ask our front desk staff or call our office if you have any questions. Thank you.

Name of Child/Adolescent:_____ DOB: _____

Name of person completing this form: _____

Relationship to child: _____

**Who has legal custody or guardianship of child? _____

**Custody documents included or already given to our office? _____

Who referred your child? _____

What is their concern? _____

_____

What is your concern? _____

What is the school's primary concern? _____

When did you first become aware of these concerns? _____

FAMILY DATA

FATHER - Name:_____ DOB: _____

Address:_____

Home Phone:_____ Work Phone: _____

Place of Employment:_____ Title:_____

Highest Level of Education:_____ Religious Affiliation: _____

MOTHER - Name:_____ DOB: _____

Address:_____

Home Phone:_____Work Phone: _____

Place of Employment:_____Title:_____

Highest Level of Education:_____Religious Affiliation: _____

STEPMOTHER (if applicable) - Name:_____DOB:_____

Address:_____

Home Phone:_____Work Phone: _____

Place of Employment:_____Title:_____

Highest Level of Education:_____Religious Affiliation: _____

STEPFATHER (if applicable) - Name:_____DOB:_____

Address:_____

Home Phone:_____Work Phone: _____

Place of Employment:_____Title:_____

Highest Level of Education:_____Religious Affiliation: _____

List in chronological order the names of all siblings, stepbrothers and sisters, half brothers and sisters. Also give a brief description of each child:

Name *Age* *School Status* *Psychiatric History* *Relationship*

_____

_____

_____

_____

_____

List any other adults or children living in the home:

Name *Age* *School Status* *Psychiatric History* *Relationship*

_____

_____

_____

How long at present address?_____Does child have own room?_____own bed? _____

Does home have running water?_____Electricity? _____

DEVELOPMENTAL INFORMATION

Length of Pregnancy:_____Birth Weight: _____

Any complications during pregnancy/birth? _____

Maternal depression and/or anxiety during pregnancy/shortly after birth?_____

Nature of delivery: Natural_____Caesarian_____Breech _____

Condition of child at time of birth: _____

Any medications, alcohol, or other substances used during pregnancy? _____

_____

Please give age your child crawled: _____ Walked: _____ Talked: _____ Toilet trained: _____

Child consolable as an infant? _____ Liked to be held? _____ Easily fed?_____

Was child adopted? (explain) _____

EDUCATION HISTORY

Current School:_____Grade:_____

If child is not enrolled, name last school attended, grade achieved, date withdrawn, and reason:

_____

Have any grades been repeated? _____

Has the child been identified for special education, learning support or emotional support (IEP or 504 plan)? Please explain:

_____

_____

_____

Speech Therapy? _____ Occupational Therapy? _____ Require 1:1? _____

Please check the items below that you feel pertain to your child:

_____Often fails to finish things
_____Easily distracted
_____Has difficulty concentrating
_____Shifts excessively from one activity to another
_____Day dreams or gets lost in his/her thoughts
_____Frequently disruptive in class
_____Has difficulty awaiting his/her turn (i.e. games)
_____Has difficulty sitting still
_____Impulsive or acts without thinking
_____Poor relationship with parents
_____Severe temper tantrums, outbursts
_____Negative peers - hangs with others that get in trouble

_____Argues a lot, bragging, boasting
_____Mean to others
_____Running away
_____Lying
_____Will not follow limits set by parents
_____Abusive to animals
_____Property destruction (i.e. vandalism, destructive)
_____Physically abusive to self (scratches self, suicidal attempts)_____
_____Fire setting
_____Stealing, Shoplifting, Breaking and Entering
_____Drug Abuse (explain) _____
_____Alcohol Abuse (explain) _____
_____Any involvement with juvenile court (explain)_____
_____Unrealistic fears (explain) _____
_____Acts too young for his/her age
_____Clings to adults or too dependent
_____Feels no one loves him/her
_____Gets teased a lot
_____Complains of loneliness
_____Demands a lot of attention
_____Easily made jealous
_____Refusal to attend school
_____Avoids being left alone
_____Excessive need for reassurance
_____Very self-conscious or easily embarrassed
_____Often appears tense and unable to relax
_____Frequent physical complaints (i.e. headaches, stomach aches, nausea)
_____Overly concerned with future events
_____Nervous mannerisms (i.e. nail biting, thumb sucking, rocking)
_____Feelings of inadequacy
_____Refuses to speak in certain situations
_____Panic – feelings of intense fear/discomfort with palpitations, tremors, shortness of breath, choking feelings, etc.
_____Obsessions – unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. (Fear of contamination, extreme concern with order, symmetry or exactness).
_____Can't get his/her mind off certain thoughts
_____Fears he/she may do something bad
_____Fears she/he has to be perfect
_____Strange thoughts or ideas (Explain) _____
_____Hallucinations (Describe) _____
_____Inappropriate expression of feelings (i.e. laughing at something sad)
_____Poor personal hygiene (not bathing for days, no interest in appearance)
_____Concern that others are watching them, following them, and/or "out to get them"
_____Severe mood changes (i.e. very sad to very happy):_____
_____Often appears sad
_____Confused or seems to be in a fog
_____Decreased energy
_____Social withdrawal
_____Overtired/fatigue
_____Negative outlook toward the future
_____Excessive tearfulness or crying
_____Underactive, slow-moving, lethargic
_____Recurrent thoughts about death or preoccupation with death
_____Suicidal thoughts or statements: _____
_____Sleep difficulties (i.e. sleepwalking, restless, inability to fall asleep or sleeps too much) (Explain) _____
_____Eating difficulties (i.e. has difficulty keeping food down, overeats, poor appetite, fear of trying

new foods, tremendous concern about weight)_____
_____Has difficulty making or keeping friends
_____Does not associate with people his/her own age
_____Avoids unfamiliar social situations
_____Changes in schedule are difficult
_____Need for high degree of supervision
_____Low frustration tolerance, irritability
_____Preoccupied with a specific person/character or object _____
_____Very sensitive to textures, sounds, and/or smells: _____
_____Delayed or absent speech: _____
_____Preoccupied with parts of objects(i.e. plays with wheel, but not the entire toy car): _____
_____Enuretic (urinates during the day or night on self)
_____Encopretic (soils self)
_____Deliberately harms self
_____Uncoordinated, accident-prone
_____Tics (sudden rapid, recurrent movements or sounds)
_____Concerns about sexual identity
_____Sexually promiscuous
_____Inappropriate sexual behavior (Explain) _____

Have there been any significant stressors or traumas to the family and child?

_____

_____

_____

Has this child ever been exposed to abuse (physical, sexual, and/or emotional)?

_____

_____

If so, has CPS been notified? Please explain:

_____

_____

PSYCHIATRIC/PSYCHOLOGICAL/MEDICAL

Family Physician/Pediatrician: _____

Psychiatrist: _____

Therapist/Counselor:_____

Medications your child has been on in the past for mood or behavior:

Name: *Dose:* *Reason stopped/side effects:*

_____

_____

_____

_____

_____

What medication(s) is your child taking now?

Name: *Dose:* *Helpful?:*

_____

_____

_____

_____

List any allergies to any medications:

_____

_____

If your child has ever been hospitalized for psychiatric reasons, please explain:

Name of Hospital: *Dates:* *Diagnosis/Behavior:*

_____

_____

_____

MEDICAL

Please check if any of the following pertain to your child; please explain (use back of page if necessary).

_____Heart Murmur	_____Heart condition	_____Nausea or vomiting	_____Diarrhea
_____Concussion	_____Seizures	_____Fainting	_____Lung Disease
_____Jaundice	_____Diabetes	_____High fevers	_____Asthma
_____Liver Disease	_____Dietary problems	_____Skin Disease	_____Major Surgeries
_____Hearing problems	_____Visual problems	_____Speech problems	
_____Urinary problems	_____Bowel or elimination problems		
_____Activity limitations	_____Other: _____		

Is child active/exercise regularly? _____

Diet: #fruits/vegetables daily?_____ #of sodas daily _____ #fast food meals daily _____

Media: #hours on phone daily? _____ #hrs of TV daily _____ #hrs video games daily _____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please list any conditions that apply to your child's blood relatives (example: depression, anxiety, panic attacks, psychosis, bipolar disorder, alcohol abuse, other substance use, suicide attempt, etc.; Medical: heart condition, sudden death, seizures, etc.).

Child's Mother :_____

Child's Father:_____

Child's Brother(s) :_____

Child's Sister(s): _____

Child's Grandparent(s): _____

NOTE: Email address for Telehealth (Zoom app) for use during pandemic: _____

I certify that the above information is true and complete.

Signature:_____Date:_____

~END OF QUESTIONNAIRE, THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM~