A New Tomorrow
Behavioral Health Services

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Child & Adolescent Intake

The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our providers. As you complete this form, feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.

General Information:

Date: _____ Gender: _____

Patient Name: _____

Date of Birth: _____ Patient's Social Security Number: _____

Parent/Guardian: _____

Home Address: _____

Street City/State Zip

Home/Primary Phone: _____

Cell Phone: Mother: _____ Father: _____

Email: _____

School: _____ Grade: _____

School's Telephone Number: _____

Teacher(s): _____

Does client attend special classes at school? ___ yes ___ no

If yes, explain: _____

Parents/Guardians and Family Information:

Mother's Name: _____ Age: _____

Occupation: _____ Education Completed: _____

Father's Name: _____ Age: _____

Occupation: _____ Education Completed: _____

Marital Status (circle one): Married Remarried Divorced Separated Widowed Single Cohabitants

Siblings: List IN ORDER BY AGE siblings of child/adolescent for whom you are seeking services.

Sibling Name	Age	School	Grade Year	Conduct*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*(Please indicate good, fair, or poor conduct)

How would you say the child for whom you are seeking services gets along with their siblings?

_____ Great _____ Very Good ____ Good ____ Fair ____ Poor ____ Very Poor

Describe: _____

_____

Family History

Has anyone in the birth family had any of the following psychological disorders?

Yes	Condition	Family Member
___	General Developmental Delays or Cognitive Delay	_____
___	Speech or Communication Disorder	_____
___	Intellectual Disability (mental retardation)	_____
___	Attention-Deficit / Hyperactivity / Impulsivity	_____
___	Learning Problems / Disabilities	_____
___	Autism Spectrum / Asperger's Disorder	_____
___	Sleep Disorders	_____
___	Generalized Anxiety (across many situations)	_____
___	Social Anxiety	_____
___	Obsessive-Compulsive Disorder	_____

___ Phobias _____

___ Depression _____

___ Manic-Depression / Bipolar Disorder _____

___ Suicide Attempts / Suicide _____

___ Schizophrenia or other psychosis _____

___ Alcohol / Substance Abuse _____

___ Seizures or other neurological disorder _____

___ Genetic Disorder (e.g., Down Syndrome, Fragile X) _____

___ Other: _____

Medical History

Name of child's Primary Care Physician: _____

Physician's Address: _____

_____

Physician's Phone: _____

List any other physician or health professional your child sees on a regular basis:

_____

When was your child last seen by a physician? _____

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had:

_____

_____

List any medications your child is currently taking. Also, list previous medications and dates if taken for an extended period of time. Use back of page if needed.

_____

_____

Patient Psychiatric History

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was the presenting issues?

_____

_____

Behavior Management / Discipline

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed: (circle the appropriate number)

	Very Unlikely				Very Likely
Let situation go	1	2	3	4	5
Time out	1	2	3	4	5
Send to room	1	2	3	4	5
Take away a privilege (ex., no TV)	1	2	3	4	5
Take away something material (ex., no toy)	1	2	3	4	5
Assign an additional chore	1	2	3	4	5
Ground child	1	2	3	4	5
Reason with child/problem solve/negotiate	1	2	3	4	5
Yell at child	1	2	3	4	5
Physical punishment	1	2	3	4	5
List anything else you may do:					
_____	1	2	3	4	5
_____	1	2	3	4	5

Please list the five things that you would like your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

	Would like Child to do More Often	Would like Child to do Less Often
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Current Symptoms:

Please indicate if your child is experiencing any of the following:

- o School attention/concentration problems
- o Grades dropping or consistently low
- o Hyperactive, difficulty being still
- o Impulsive, doesn't think before acting
- o Sadness or Depression
- o Generalized Anxiety (across many situations)
- o Specific fears/phobias (list): _____
- o Social Anxiety
- o Obsessive-Compulsive/Rigid behavior patterns
- o Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
- o Isolated socially from peers
- o Problems making or keeping friends
- o Problems with eating
- o Problems with falling asleep
- o Problems sleeping through the night (middle of the night or early morning waking)
- o Trouble waking up
- o Fatigue/tiredness during the day
- o Nightmares
- o Noncompliant, purposely does not obey (not due to language or cognitive deficits)
- o Oppositional, defiant behavior
- o Problems controlling temper
- o Tantrums/ "meltdowns"
- o Problems with authority (breaking rules or laws)
- o Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)
- o Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)
- o Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)
- o Wetting accidents (indicate day or night wetting):_____
- o Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)
- o History of abuse (emotional, physical, sexual)
- o Alcohol or drug use/abuse
- o Vocal or motor tics (e.g., grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)
- o Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)
- o Stress from conflict between parents
- o Stress due to family financial problems
- o Legal situation (anyone in family)

Other behavioral problems: _____

Legal History

Have you ever filed or been involved in any litigation? Please explain

_____

_____

Is there anything else we should know about your child that was not covered by this form?

_____

_____

Insurance:

Primary Insurance: _____ ID Number: _____

Name of Insured: _____ Insured's Date of Birth: _____

Insured Address: _____ Phone: _____

Secondary Insurance: _____ ID Number: _____

Name of Insured: _____ Insured's Date of Birth: _____

Insured Address: _____ Phone: _____

Responsible Party:

Name: _____ Relationship: _____

Address:_____

Primary Phone: _____ Alternate Phone: _____

I authorize this provider to release any information, including diagnosis, treatment plans / records to third party payers and / or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the provider or medical benefits that are, otherwise, payable to me. I understand that my medical insurance may pay less than the actual bill for service or may not cover certain treatment.

I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this medical office. I accept responsibility and understand that I am responsible for the charges and fees that are due at the time service is provided, unless I make arrangements in advance.

Signature: _____ Date: _____