AccessLiving
Counseling and Developmental Services

Child/Adolescent Intake Form

Today's date: _____

Patient Information:

Individual Name: _____Date of Birth: ____/____/_____ Age: _____
(First) (Last)

Gender: Male Female Ethnicity (optional): _____

Name of Person completing this form:

_____

Relationship to individual: _____ Years known: _____

Residence of child: (circle one) Biological parents Adoptive parents Foster parents PCS Home

Other: _____

Patient Contacts:

Mother's name: _____ Age: _____
(First) (Last)

Father's name: _____ Age: _____
(First) (Last)

Marital Status of Parents: (circle one) Married Divorced Separated Widowed

Mother's Address: _____
(street) (city) (state) (zip)

Father's Address: _____
(street) (city) (state) (zip)

Contact phone numbers:

Name/Relationship: _____ Number: _____

Who has legal/physical custody? _____ Type: _____
(please provide legal documentation)

Support Services:

Does this individual receive services from Health and Welfare? ☐ Yes ☐ No

Case Worker: _____ Phone: _____

Services Received: _____ Region:

_____

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Presenting Problem:

_____
_____
_____
_____

What concerns you most about this individual?

_____
_____
_____
_____

When did you first notice this problem?

_____
_____
_____
_____

How has this problem affected his/her function?
At home:

_____
_____

At school/work:

_____
_____

Community:

_____
_____

Do you have other concerns you want addressed?

_____
_____

Have you recently worried that your child has (please circle items relevant to your child):
Yes No DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)
Yes No MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)
Yes No ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)
Yes No BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)
Yes No ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)
Yes No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

Yes No SOCIAL ANXIETY (shy and/or afraid to be around others)
Yes No REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)
Yes No AUTISM (social and language impairments, rigidity)
Yes No PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)
Yes No DISSOCIATION (feeling outside your body or things are not real, etc.)
Yes No Has your child ever harmed themselves intentionally? Attempted suicide? Harmed others?

Sleep Patterns:
Total hours of sleep per night: Usual Schedule: to
Does the individual take naps during the day? Yes No
If Yes, how many hours in a typical day?

Concerns:	Current Problem	Change within last 6 months
Difficulty falling asleep:	Yes No	Yes No
Frequent awakening:	Yes No	Yes No
Snoring:	Yes No	Yes No
Restlessness/Movements:	Yes No	Yes No
Early morning awakening:	Yes No	Yes No
Nightmares:	Yes No	Yes No
Not rested:	Yes No	Yes No

If yes to any of the concerns listed above, please describe:
Past Psychiatric History:
Please list any previous psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs)
Diagnosis Length of Stay Treatment Response
Please list any current or prior outpatient psychiatrists and therapists your child has seen?
Name Title Location How Long?

Drug and Alcohol History:

Substance	**Date of Last Use**	**Problems Related to Use**	**Treatment Required**
Benzodiazepines (Valium, Xanax, Ativan)	Yes No	Yes No	
Caffeine	Yes No	Yes No	
Marijuana	Yes No	Yes No	
Cocaine	Yes No	Yes No	
Designer Drugs (Club Drugs: G, X)	Yes No	Yes No	
Hallucinogens (LSD, Mushrooms)	Yes No	Yes No	
Inhalants (Gasoline, Glue, Aerosol)	Yes No	Yes No	
Methamphetamines (Speed, Ice, Ritalin)	Yes No	Yes No	
Opiates/Methadone (Vicodin, OxyContin, Heroin)	Yes No	Yes No	
OTC – *Over the counter*	Yes No	Yes No	

(Benadryl, Nyquil, Dramamine)

Tobacco: none Amount per day:
Anything else we need to know about your drug history:

Please list this individual's current medications (psychiatric and non-psychiatric).
(You may refer to the list of medications on the next page.)
(To ensure accuracy, please take this information directly from your prescription bottles/containers.)

Medication Dose Route How Often? What time? Prescriber

Please list all the psychiatric medications that have been tried in the past.

Medication Dose Duration Response Reason for stopping

Do you take over the counter medications or herbal supplements? No Yes (List)

Medication Dose Route How Often? What time?

Medications:

Adderall® (dextroamphetamine + amphetamine)
Abilify® (aripiprazole)
Adipex-P® (phentermine)
Ambien® (zolpidem)
Amoxapine
Antabuse® (disulfiram)
Anafranil® (clomipramine)
Aricept® (donepezil)
Ativan® (lorazepam)
Aventyl® (nortriptyline)
Belsomra® (suvorexant)
Benadryl® (diphenhydramine)
Buspar® (buspirone)
Campral® (acamprosate)
Carbatrol® (carbamazepine)
Catapres® (clonidine)
Celexa® (citalopram)
Chantix® (varenicline)
Chloral hydrate
Clozaril® (clozapine)
Cogentin® (benztropine)
Concerta® (methylphenidate)
Cymbalta® (duloxetine)
Cylert® (pemoline)
Dalmane® (flurazepam)
Depakote®/Depakene® (valproic acid/ valproate)
Dexedrine® (dextroamphetamine)
Didrex® (benzphetamine)
Dilantin® (phenytoin)
Dolophine®/Methadose® (methadone)
Effexor XR® (venlafaxine)
Elavil® (amitriptyline)
Ephedra®
Eskalith® (lithium)
Evening primrose oil
Focalin® (dexmethylphenidate)
Gabitril® (tiagabine)
Geodon® (ziprasidone)
Ginkgobiloba
Kappra® (levetiracetam)
Lamictal® (lamotrigine)
Latuda® (lurasidone)
Lexapro® (escitalopram)
Marplan® (isocarboxazid)
Meridia® (sibutramine)
Metadate® (methylphenidate)
Methylin® (methylphenidate)
Minipress® (prazosin)
Moban® (molindone)
Mysoline® (primidone)
Nardil® (phenelzine)
Navane® (thiothixene)
Neurontin® (gabapentin)
Norpramin® (desipramine)
Nortriptyline (Pamelor®)
Omega fatty acids
Orap® (pimozide)
Pamelor® (nortriptyline)
Parnate® (tranylcypromine)
Paxil® (paroxetine)
Periactin® (cyproheptadine)
Prolixin® (fluphenazine)
Propranolol (Inderal®)
ProSom® (estazolam)
Protriptyline (Vivactil®)
Provigil® (modafinil)
Prozac® (fluoxetine)
Quillivant® (methylphenidate)
Remeron® (mirtazapine)
Restoril® (temazepam)
ReVia® (naltrexone)
Risperdal® (risperidone)
Ritalin® (methylphenidate)
Rozerem® (ramelteon)
SAM-e
Saint john's wort
Sarafem® (fluoxetine)
Serax® (oxazepam)
Seroquel® (quetiapine)
Serzone® (nefazodone)
Sinequan® (doxepin)
Sonata® (zaleplon)
Stelazine® (trifluoperazine)
Strattera® (atomoxetine)
Subutex® (buprenorphine)
Suboxone® (buprenorphine + naloxone)
Symbiax® (olanzapine + fluoxetine)
Tegretol® (carbamazepine)
Tenex® (guanfacine)
Tenuate® (diethylpropion)
Thorazine® (chlorpromazine)
Tofranil® (imipramine)
Topamax® (topiramate)
Tranxene® (clorazepate)
Trazodone (Desyrel®)
Trilafon® (perphenazine)
Trileptal® (oxcarbazepine)
Valerian
Valium® (diazepam)
Vistaril® (hydroxyzine)
Vyvanse® (lisdexamfetamine)
Wellbutrin® (bupropion)
Xanax® (alprazolam)
Zarontin® (ethosuximide)
Zoloft® (sertraline)
Zonegran® (zonisamide)
Zyprexa® (olanzapine)
Zydis® (olanzapine)

Family History:
Consider this individual's immediate family and all of their relatives on both sides (parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins)
Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Uncle") and their treatment history (if applicable). Maternal is mother's side of the family and Paternal is father's side of the family.
Depression
Anxiety
ADHD
Bipolar (manic depressive)
Schizophrenia
Alcohol/Drug Problems
Learning Disabilities
Autism/Asperger/Pervasive Developmental Disorder
Mental Retardation
"Nervous Breakdown"
Psychiatric Hospitalizations
Suicide (or attempts)
Panic Disorder
PTSD (Post Traumatic Stress Disorder)
OCD (Obsessive Compulsive Disorder)
Seizures
Migraines
Heart or lung problems
Thyroid
Immunological disorders (lupus, scleroderma, inflammatory bowel disease)
Cancer
Other

Developmental History:
Did your child achieve the following milestones early (E), average (A), or late (L) compared with other children his/her age (please explain if late):
Language (age at first using words, sentences, etc.…)?
Fine motor skills (building towers with cubes, drawing circle)
Gross motor skills (rolling over, standing, walking)?
Toilet training?
Has your child experienced any regression of these? Yes No If yes, explain:

Pregnancy and Birth History:
How old was this child's biological parents when he/she was conceived?
Was this the biological mother's first pregnancy? Yes No
If no, how many times was she pregnant before this pregnancy?
Did the biological mother experience any miscarriages before or after this pregnancy? Yes No
If yes, how many? During what trimester?
When was prenatal care first received (in weeks):
How much weight did the biological mother gain during this pregnancy?:
Baby's birth weight and length:
Length of pregnancy (in weeks):
Did the mother have any ultrasounds or amniocentesis? Yes No If yes, please describe the reason for these and the results:
Please indicate whether any of the following events/problems occurred during this pregnancy. Please

include the trimester in which the event occurred, as well as any other important details.

	Yes / No	# of months into pregnancy	Additional details
Infections/Colds	Yes No		
Fevers	Yes No		
Hospitalizations	Yes No		
Vaginal bleeding, spotting	Yes No		
Problems with diet	Yes No		
Pregnancy induced Hypertension	Yes No		
High blood pressure, excessive swelling	Yes No		
Diabetes	Yes No		
Rh or Blood Incompatibilities	Yes No		
Trauma (emotional stress and/or physical injury)	Yes No		

Did you take any medications (prescription and over the counter) during this pregnancy? (If yes, please complete the following table.)

Medication	Month(s) taken (1-9)	Dose	Reason for taking

Did you consume alcohol during this pregnancy? Yes No
If yes, how much and how often?
Did you smoke or use tobacco products during this pregnancy? Yes No
If yes, please describe how much and how often?
Did you use any drugs during this pregnancy? Yes No
If yes, please name drug(s), how much and frequency of use:

Labor Information:

Type of delivery (c-section, vaginal):
Were forceps used?
Were there any problems with the baby's health right before or immediately after delivery? Yes No
If yes, please describe:
Were the mother and/or baby separated after birth for more than 24 hours at a time? Yes No
If yes, please explain:

Past Medical History:

Primary Care Provider: Years Involvement:
Phone:
Address:
Approximate Date of Last Visit:
Number of Visits in Last Year:
Other Provider(s):
Specialty:
Name: Phone:
Address:
Other Provider(s):
Specialty:
Name: Phone:
Address:
Allergies (drug, food, seasonal, environmental etc.)? Yes No If yes, please name and describe your child's reaction:
Has your child ever experienced a head injury, loss of consciousness, or seizure? Yes No
If yes, please describe:
Does your child have any chronic medical problems? Yes No If yes, please describe:

Does your child have a history of any serious injuries or medical hospitalizations? Yes No
If yes, please describe:
Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? Yes No
If yes, please describe:
Do you have any concerns related to your child's balance or ability to walk?

_____
Has your child had a significant unintentional or unexpected fall in the past year?

_____
(consider referral to STARS if yes)
In the past year, has your child lost or gained weight without meaning to?
How much and in what time frame?

_____
How many meals a day does your child eat?

_____
Have you recently worried that your child may have problems with:
Heart Constipation/Diarrhea Age of first menses
Lungs Frequent infections Regular or Irregular cycle
Kidneys/Bladder Endocrine (i.e., diabetes; thyroid dysregulation; excessive hair growth)
Neurological Immunizations up to date
Has your child ever had an EEG, MRI, CT SCAN, etc? Yes No
If yes, why was it done and were the results normal?
If yes, where were the tests performed and who ordered them?

Social History:

Is your child your biological child? Yes No
If no, at what age was he/she adopted?
Is there any contact with their biological parent(s)?
Where was your child born and raised?
Allergies (drug, food, seasonal, environmental etc.)? Yes No If yes, please name and describe your child's reaction:
Has your child ever experienced a head injury, loss of consciousness, or seizure? Yes No
If yes, please describe:
Does your child have any chronic medical problems? Yes No If yes, please describe:
Does your child have a history of any serious injuries or medical hospitalizations? Yes No
If yes, please describe:
Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? Yes No
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If yes, where were the tests performed and who ordered them?
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Is your child your biological child? Yes No
If no, at what age was he/she adopted?
Is there any contact with their biological parent(s)?
Where was your child born and raised?

Has your child moved a number of times? Yes No
If yes, please list their age at time of move and location:

Parents: (Including Step-Mother and Step-Father, if applicable)
Name Education Occupation Hrs/Wk Relationship with Child (quality)
Please list the other children in the family and other household members who may also be living in your home:
Name Age Lives at Home? Relation to Child Relationship with Child
Abuse History:
Has your child ever been the victim of abuse or neglect? Yes No
If yes, what was the nature of the abuse? (Please circle all that apply.)
Physical Emotional Neglect
Accidents Disasters Sexual

Witnessing violence Other
Are you struggling with your marital relationship or parenting? Yes No
If yes, please describe:
Has your child ever been involved with the following and if yes, please explain:
Yes No Child Protective Services
Yes No Childrens Mental Health
Yes No Probation/Juvenile Probation/Detention
Yes No Boys and Girls Club
Yes No Youth Services
Yes No Head Start
Yes No Early Intervention Services (ages 0-3)

School:

Where does your child attend school?
In what grade level is he/she?
What are his/her typical grades?
What are your child's academic strengths?
Academic weaknesses?
Has there been a change in your child's performance at school? Yes No If yes, please describe:
Has your child received IQ or Academic testing? Yes No If yes, what were the results?
Does or has your child participated any of the following?
Yes No Resource (for which classes/how many hours?)
Yes No Accelerated or Honors programs, explain:
Yes No 504 Plan, explain:
Yes No Individual Education Plan (IEP), explain:
Yes No Virtual Academy, explain:
Has your child had problems with any of the following?
Yes No Truancy, explain:
Yes No Fights, explain:
Yes No Absenteeism, explain:
Yes No Detention, explain:
Yes No Suspension, explain:
Yes No School refusal, explain:
What are your child's favorite activities?
How does your child learn best?
Verbal explanations_____
Written informational handouts_____

Other _____
Does your child have any significant problems that might affect learning? (Such as, trouble seeing or hearing, difficulty in understanding, speaking a different language, other)
_____
_____
_____
_____
Peers:
Does your child have quality relationships with other children? Yes No If no, please explain:
Culture:
Do you have a religious preference in the household? Yes No If yes, what is that preference?
Has your child experienced any problems related to race, religion, or culture? Yes No If yes, please explain:

TEEN/YOUNG ADULT SECTION
Do you have any concerns regarding your adolescent's friendships? Yes No
(Please circle all that apply.)
Too old Too young Truant Gang Fringe
Drug/alcohol use Violence Too many Too few Sexual Promiscuity
Too much time together Other
Has your adolescent had a recent change in friendships? Yes No If yes, what changes, if any are concerning to you?
Are you concerned that your adolescent is using (or has used) drugs (including over the counter medicines) or alcohol? Yes No If yes, please describe:
Are you concerned about your child's sexual activities? Yes No
Is your adolescent sexually active? Yes No
Does your adolescent have a job? Yes No
Has your adolescent's behavior ever resulted in police, detention, or court involvement? Yes No
If yes, please explain:

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Is there anything else you would like us to know about your child?