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New Patient Intake Form for Children & Adolescents

Of all the forms you fill out today, this is probably the most important one. Yes, it is long. But, the information you provide in this form is absolutely necessary for a full, and accurate, evaluation.

Dr. Vereb would much prefer that you complete this form before your visit. That way, he does not need to spend valuable time asking you these questions during the visit.

If he can review this information before your visit, Dr. Vereb can then spend the full time of your appointment really focusing in on the main problems that brought you here today.

If you have any questions at all about this form, please don't hesitate to ask!

All of the information you provide on this form is absolutely confidential.

Thank you!

Today's Date: _____
Child's Name: _____ DOB: _____

Ethnicity/race: _____ Soc Sec #: _____

Gender: ☐ Male ☐ Female Primary language if other than English: _____

Person answering questions: _____ Relationship: _____

Person who assisted in completing this form: _____

Who has current custody/guardianship of child? ☐ mother ☐ father ☐ both parents ☐ DSHS

☐ relative: _____ ☐ other: _____

If the Legal Guardian is someone other than the parents complete the following:

Name: _____

Address: _____

Phone: _____

Relationship to child: _____

Comment on history/potential for changes in custody: _____

_____

Mother/Maternal Caregiver Information:

Relationship to child: ☐ biological ☐ adoptive ☐ foster ☐ step ☐ other_____

Mother's name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Years of Education/Degree: _____

General Health: _____

Father/Paternal Caregiver Information:

Relationship to child: ☐ biological ☐ adoptive ☐ foster ☐ step ☐ other_____

Father's name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Years of Education/Degree: _____

General Health: _____

Step Mother's Name (if applicable): _____

Step Father's Name (if applicable): _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Insured's name: _____

Insured's DOB: ___/___/___

With whom is this child currently living (list other members of household):

Name	Gender	Age	Relationship
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

Please indicate the type of living situation in which the child resides: ☐ family home ☐ non-parent relative caregiver ☐ foster home ☐ group home ☐ other: _____

Has family had multiple moves (3+) in the past 12 months? ☐ Yes ☐ No

Has family experienced homelessness in the past 12 months? ☐ Yes ☐ No

OUT-OF-HOME PLACEMENT HISTORY (IF APPLICABLE)

Has the child ever been separated from his/her parents/primary caregivers for any significant periods of time? ☐ Yes ☐ No

How many out-of-home placements has the child had in the past 12 months? _____

Provide information about the child's age, circumstances of the separation, and child's response: _____

_____

_____

_____

How did the move(s) affect the child: _____

Is the child currently at risk for out-of-home placement? ☐ Yes ☐ No If yes, why: _____

REASONS FOR EVALUATION

Who referred you to this clinic: _____

Please state your concerns; specify nature of problem, onset, duration, frequency, and severity: _____

_____

_____

_____

_____

What do you hope to get from this evaluation/treatment? _____

_____

_____

_____

DEVELOPMENTAL HISTORY

Any concerns about the child's development? ☐ Yes ☐ No.

Was development perceived as being ☐ average? ☐ below average? ☐ above average? Please identify your child's developmental progress in the following areas:

Areas of Development	***Compare your child's development to other children his/her age (please put an X in the box below):***			***Please comment on areas of strength and needs in your child's development:***
	About the same	Slower	Faster	Please note any delay/ deterioration/ loss of skills
Gross Motor Skills (running, throwing ball, bicycling)				
Fine Motor Skills (coloring, drawing, writing, scissors use)				
Speech & Language Skills (pronunciation, vocabulary)				
Social Skills (sharing, cooperating, taking turns)				
Self-Control Skills (impulse control, delaying gratification)				
Self-Concept (child's opinion of self, abilities, worth)				
Cognitive Skills (memory, comprehension, knowledge)				

Has your child had any formal developmental testing? ☐ Yes ☐ No If yes, please provide details: _____

_____

_____

Has your child received any early intervention services? o Yes o No If yes, please provide details about the services and provider(s): _____

_____

_____

Can your child perform the following tasks without help: (check if yes)

- ❑ eat using a spoon and fork? _____
- ❑ cut meat/food with a knife? _____
- ❑ drink from a glass? _____
- ❑ undress? _____
- ❑ dress alone? _____
- ❑ tie shoelaces? _____
- ❑ toilet him/herself? _____
- ❑ bathe him/herself? _____

CHILD'S MEDICAL/PHYSICAL HISTORY

Who is the child's primary doctor? _____ Phone #: _____

Address: _____

Who is the child's primary dentist? _____ Phone #: _____

Address: _____

When was your child last seen by a physician? _____

For what reason? _____

Date and results of last physical examination: _____

_____

Child's current height: _____ weight: _____

Is the child's general physical health good? ☐ Yes ☐ No

Serious and/or chronic illness now (or in past)? _____

Sleep problems (too much/too little)? _____

Are immunizations up to date? ☐ Yes ☐ No

Does the child have any of the following impairments/conditions (documented)? ☐ None reported

☐ Unknown ☐ developmental disability ☐ visual disability ☐ Deaf ☐ Hard of hearing

☐ medically compromised ☐ medical/physical disability ☐ neurological disability ☐ FAS/FAE

☐ Chronic medical/neurological condition which affects psychological functioning ☐ Other: _____

Has child had any history of seizures or head injury ☐ Yes ☐ No (if yes, specify type, duration, frequency and date of last EEG)? _____

_____

Has the child had any serious injuries/accidents or episodes with loss of consciousness? ☐ Yes ☐ No

If yes, please provide details: _____

History of medical hospitalizations and/or surgeries: ☐ None reported ☐ Unknown

Provider Name(s):	Dates/duration:	Conditions treated:	Complications:	Discharge status:

Current ongoing use of non-psychotropic medications for physical health: ☐ None reported ☐ Unknown

Name of medication(s):	Condition(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

Homeopathic, naturopathic, herbal and/or other alternative medicine treatments for physical health: ☐ None reported ☐ Unknown

Current	Past	Name of treatment:	Condition(s):	Prescribing MD:	Response/side effects:

Medication Allergies: _____

Has your child had any of the following (please give details):

- ❑ recurrent headaches _____
- ❑ recurrent stomach aches _____
- ❑ recurrent diarrhea _____
- ❑ recurrent vomiting _____
- ❑ constipation _____
- ❑ vision problems _____
- ❑ hearing problems _____
- ❑ ear infections _____
- ❑ recurrent respiratory infections (bronchitis/bronchiolitis or pneumonia) _____
- ❑ allergies _____
- ❑ wheezing or asthma _____
- ❑ bladder problems _____
- ❑ problems with urination _____
- ❑ weight loss or gain _____
- ❑ skin problems _____
- ❑ problems with bones, muscles or joints _____
- ❑ tremor, shakes or jitters _____
- ❑ tics or other movement problems _____
- ❑ wets bed or him/herself _____
- ❑ soils bed or him/herself _____
- ❑ other _____

Does your child have any pain issues or concerns? ☐ Yes ☐ No If yes, explain: _____

Sexual Development (menstruation history, sexual activity, use of contraception, pregnancy history):_____

_____

CHILD SOCIAL-BEHAVIORAL AND PSYCHIATRIC HISTORY

How is your child's overall emotional health? _____

_____

List all past outpatient psychiatric/psychological/mental health services: ☐ None reported ☐ Unknown

Provider Name(s):	Dates of tx:	Services provided:	Outcomes:	Termination reason(s):

List any history of psychiatric hospitalization and/or residential treatment: ☐ None reported ☐ Unknown

Provider Name(s):	Dates of tx:	Services provided:	Outcomes:	Discharge status:

Psychotropic medication history for behavioral health: ☐ None reported ☐ Unknown

Current	Past	Name of medication(s):	Condition(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

Please list all other persons or agencies who have evaluated your child in the past:

Type of service	Service provider/address	Results	Dates

Does your child have behavior problems at home? (please specify): _____

_____

_____

Does your child have behavior problems at school? (please specify): _____

_____

_____

Does your child have behavior problems in the community (e.g. grocery store, daycare, public places, etc)? (please specify): _____

_____

_____

Does the child have any past/ current substance use/abuse? ☐ cigarettes ☐ drugs ☐ alcohol ☐ drugs/alcohol ☐ denies use ☐ remission 90+ days ☐ none If yes, please describe substances used, amount, and effect on child's performance at home and school: _____

_____

_____

Has the child engaged in any law breaking behavior? o Yes o No (Provide details about history of arrest, detention, gang involvement, diversion, etc.): _____

_____

_____

Has the patient had any history of the following emotional/behavioral problems:

- ☐ specific phobias: _____
- ☐ firesetting: _____
- ☐ animal mistreatment: _____
- ☐ enuresis/encopresis (bedwetting, soiling): _____
- ☐ self-injurious behaviors: _____
- ☐ other: _____

History of violence/grief and loss:

Has child been exposed to domestic violence? ☐ Yes ☐ No

Has child been a witness to violence or traumatic death? ☐ Yes ☐ No

Has child experienced death of parent/psychological parent? ☐ Yes ☐ No

Child abuse/neglect history:

Has child had history of ☐ physical abuse ☐ sexual abuse ☐ persistent inadequate parenting or neglect? Has abuse/neglect been documented by CPS/Legal System? ☐ Yes ☐ No _____

Has the abuse history been previously addressed by a professional? ☐ Yes ☐No If so, how? _____

Please describe forms of discipline which have been used in the home and their effectiveness: _____

Does your child have as many friends as most other children his/her age? ☐ Yes ☐ No

Does your child have friends come over and play at your house? ☐ Yes ☐ No

Does your child play at the houses of his/her friends? ☐ Yes ☐ No

Has your child had any friends stay overnight at your house, or has she/he stayed overnight at another friend's house? ☐ Yes ☐ No ☐ not age appropriate

Has child been persistently harassed or abused by peers? ☐ Yes ☐ No

Please list those qualities about your child that you consider to be strong positive points. _____

Please list those qualities about your child that you consider to be strong negative points. _____

BIRTH AND EARLY INFANCY HISTORY

This information should be provided as it relates to the biological parents of the child, if known.

Was the pregnancy planned? ☐ Yes ☐ No

Any difficulty becoming pregnant? If so, please explain: _____

Was the mother exposed to any of the following: ☐ None

TYPE	LIST SPECIFIC SUBSTANCES	AMOUNT	MONTH OF PREGNANCY
DRUGS			
ALCOHOL			
TOBACCO			
MEDICATIONS			
X-RAYS			

Did the mother experience any of the following during pregnancy? ☐ None

	DESCRIBE THE PROBLEM	MONTH OF PREGNANCY
FEVER		
FLU		
SKIN RASH		
SPOTTING/BLEEDING		
KIDNEY INFECTIONS		
VAGINAL INFECTIONS		
SWELLING OF HANDS/FEET/FACE		
HIGH BLOOD PRESSURE		
DIZZY SPELLS		
CONVULSIONS		
HEADACHES		
BLURRED VISION		
VOMITING		
OTHER ILLNESSES		

Length of pregnancy: _____ Age of mother: _____ Weight gain: _____ Describe la

☐ Natural (vaginal) ☐ C-section ☐ Forceps Please explain: _____

_____

Did the baby cry immediately after birth? ☐ Yes ☐ No Apgar scores (if known): _____ Birth statist

How soon after the birth did the mother see the baby? _____ Hold the baby? _____

Hospital where the child was born: _____ Duration of

jaundice, need for incubator/oxygen, infections, feeding problems, convulsions): _____

_____

_____

Were there any difficulties during the baby's first month of life? (excessive crying, health problems, etc.): _____

_____

_____

Was the infant ☐ bottle or ☐ breast fed ? Number of months breast fed: _____

Were there any difficulties with feeding (e.g. recurrent vomiting, "colic", poor suck, low weight gain)?

_____

Did parents have trouble adjusting to the new baby? _____

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following conditions? Check all that apply, past or present:

Condition/Circumstance	Child	Mother	Father	Sibling	Mother's Family	Father's Family
Cardiovascular disease/sudden death from cardiac reason						
Diabetes						
Mental Retardation						
Learning Disorder						
Attention Deficit						
Hyperactivity						
Epilepsy						
Neurological Disorders						
Alcohol Abuse						
Drug Abuse						
Physical/Emotional Abuse						
Sexual Abuse						
Depression						
Suicide Attempts						
Anxiety Disorders						
Specific Fears or Phobias						
Panic Attacks						
Schizophrenia						

Visual Disability/Problems						
Deaf/Hard of Hearing						
Tics/Tourette's Syndrome						
Chronic Illnesses						
Juvenile Delinquency						
Arrests/Incarceration						
Harassment by peers						
Homelessness						
Teen pregnancy						

Condition/Circumstance	Child	Mother	Father	Sibling	Mother's Family	Father's Family
School suspension/expulsion						
Special Education						
Birth Defects						
Miscarriages						
Other:_____						

SCHOOL/VOCATIONAL HISTORY

Is the patient currently enrolled in school? o Yes o No

Current school placement:

School District: _____ Grade: _____

School Name: _____ Phone #: _____

Teacher/Counselor/IEP Coordinator: _____

Is child enrolled in special education? ☐ Yes ☐ No Current IEP? ☐ Yes ☐ No (if yes, request copy) Child is designated: ☐ Seriously behaviorally disordered ☐ Learning disordered ☐ Health impaired

Child's classroom is: ☐ Regular Education ☐ Regular Education with pull-out to Resource Room

☐ Self- contained classroom ☐ Generic special education classroom

☐ Inclusion in regular education (_____hours/day) ☐ Other: _____

Describe current daily functioning in school setting (including strengths and needs): _____

_____

_____

_____

Review history of school placements and functioning: (including learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement): _____

_____

_____

Has the child been suspended/expelled in past 12 months? ☐ Yes ☐ No How many times? _____

What school interventions have been used to address problems: ☐ None ☐ Special seating arrangement

☐ Tutoring ☐ Token economy ☐ Groups ☐ Classroom aide ☐ Parent(s) called ☐ other:_____

Vocational Assessment for Youth: ☐ Not applicable

Has youth had any paid employment? ☐ Yes ☐ No If yes, provide details of employment history: _____

_____

Has youth had any significant volunteer experiences? ☐ Yes ☐ No If yes, provide details of experiences: _____

_____

_____

Family History

Do you have any family members in the area that you can rely on for help? ☐ Yes ☐ No

Do you have any friends in the area that you can rely on for help? ☐ Yes ☐ No

Do you have any other adults in the area that you can rely on for help? ☐ Yes ☐ No

Does your family have any identified religion or spiritual beliefs and practices? ☐ Yes ☐ No

_____

_____

Please describe activities that your family likes to do together: _____

_____

_____

Are there currently any unusual stresses your family is experiencing? _____

_____

_____

Is there any family conflict currently in the household in which the child resides ☐ Yes ☐ No

Is family experiencing significant family discord between 2 or more individuals? ☐ Yes ☐

No Does patient have a troubled sibling? ☐Yes ☐ No

If yes to any of the above, please provide details and effect on child: _____

_____

_____

_____

Brief statement about parents'/caregivers' own relationship: _____

_____

_____

Has there been any domestic violence in the household in which the child resides? ☐ Yes ☐ No

If yes, please provide details and effect on child: _____

_____

_____

Does the parent/caregiver have a history of substance abuse which disrupts their capacity to parent?

☐ Yes ☐ No (If yes, provide details about type of substances, use patterns, treatment history, etc.)

_____

_____

_____

Has parent/caregiver been involved in the criminal justice system? ☐ Yes ☐ No

If yes, provide details about arrests, periods of incarceration, restraining orders, outstanding legal issues, etc. _____

_____

_____

Is your current housing adequate to meet your family needs? ☐ Yes ☐ No

Please provide details on the housing and how it does/does not meet your family needs: _____

_____

Please indicate any agencies currently involved with your child and/or family:

☐ Family Reconciliation Svcs (FRS) ☐ Child Protective Svcs (CPS) ☐ At-risk youth petition (ARY)

☐ Developmental Disabilities (DDD) ☐ Juvenile Court/probation ☐ Substance abuse counseling

Details:_____

Ethnic/cultural identification of parent/child/extended family (including language spoken at home):

Immigration history (country of origin, immigration process, length of time in U.S., acculturation/ethnic identity):

Religious/spiritual practices of patient/caregivers/family:

Culturally/socially relevant beliefs regarding mental health and illness (include beliefs and attributions regarding current problem, general beliefs about illness, health, models of pathology, and treatment):

Is there anything else you would like us to know about this child that was not asked?