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NWA PSYCHIATRY
a MANA clinic

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CHILD/ADOLESCENT INTAKE FORM

CHILD'S NAME: _____TODAY'S DATE:_____

DATE OF BIRTH: _____ RACE: _____ SEX: _____

OTHER NAME YOUR CHILD PREFERS TO BE CALLED:_____

NAME OF PERSON COMPLETING FORM:_____

RELATIONSHIP TO CHILD: _____

WHO REFERRED YOU TO OUR CLINIC:_____

MAY WE CONTACT THEM: _____ YES _____NO

PRIMARY CARE DOCTOR: _____

MAY WE CONTACT THEM: _____ YES _____NO

PRIMARY CONCERNS FOR CONSULTATION: _____

_____

_____

HOW LONG HAVE THESE CONCERNS BEEN PRESENT: _____

WHAT ARE YOUR GOALS FOR TREATMENT: _____

_____

_____

WHICH OF THE FOLLOWING SYMPTOMS/CONCERNS HAS YOUR CHILD EXPERIENCED IN THE LAST 60 DAYS:

_____ Sad or depressed mood _____ Withdrawn from family or friends

_____ Loss of interest in activities or hobbies _____ Feelings of guilt or worthlessness

_____ Feeling hopeless about the future _____ Sleep disturbance _____Change in appetite

_____Low energy or fatigue _____Trouble focusing or concentrating _____Thoughts of hurting self

_____Thoughts of suicide _____Thoughts of hurting or killing others _____Irritability

_____Severe angry outbursts (verbal or physical) _____Worrying too much

_____Feeling or acting restless _____Muscle tension _____Panic or anxiety attacks

_____Fear of looking stupid or being embarrassed _____Fear of offending others

_____Any other fears or phobias _____Drastic mood swings _____Episodes of decreased need for sleep

_____Extreme hyperactivity _____Racing thoughts _____Talking so fast it's hard to understand

_____Overly happy or euphoric _____Overly confident

_____Thoughts, feelings or images that come into the child's mind when he/she does not want them to?

_____Habits the child feels they must do even if he/she knows it does not make sense (for example excessive cleaning, checking, repeating, counting, organizing or hoarding things)?

_____Hearing voices that other people cannot hear _____Odd thinking or beliefs

_____Seeing things other people cannot see _____Feeling paranoid _____Poor body image

_____Trying to lose weight even though he/she is not overweight

_____Intentionally throwing up after eating _____Easily loses temper _____Easily annoyed

_____Defiant _____Argues with authority figures _____Annoying others on purpose

_____Blaming others for his/her mistakes _____Resentful, spiteful or vindictive _____Lying

_____Stealing _____Destroying property _____Setting fires _____Skipping school

_____Hurting other people or animals _____Difficulty learning

_____Trouble understanding social cues _____ Difficulty making/keeping friends

_____Sensitive to sound, light, touch or smell

HAS YOUR CHILD EXPERIENCED A TRAUMATIC EVENT: _____ Sexual abuse _____ Physical abuse

_____ Near death experience _____ Other traumatic event: _____

_____

SOCIAL HISTORY:

WHO LIVES AT THE CHILD'S PRIMARY RESIDENCE: _____ Mom _____ Dad _____Brother(s)

_____ Sister(s) _____ Step-parent _____ Grandmother _____ Grandfather _____ Aunt _____ Uncle

_____ Cousin(s) _____ Foster parent(s) _____ Foster sibling(s)

_____ Other: _____

IS THE CHILD ADOPTED? _____ YES _____NO IS THE CHILD AWARE? _____ YES _____NO

CURRENT SCHOOL: _____ GRADE: _____

DOES YOUR CHILD HAVE AN IEP OR 504 PLAN? _____ YES _____NO. If yes, please bring a copy to the first visit.

ARE THERE CURRENT BEHAVIOR CONCERNS AT SCHOOL? _____ YES _____NO

IF YES, PLEASE EXPLAIN: _____

_____

_____

HAS YOUR CHILD BEEN SUSPENDED OR EXPELLED FROM SCHOOL? _____ YES _____NO

ARE THERE ANY CURRENT LEGAL PROCEEDINGS INVOLVING THE CHILD? _____ YES _____NO

IF YES, PLEASE EXPLAIN: _____

_____

_____

PREGNANCY HISTORY:

WAS THE PREGNANCY COMPLICATED BY ANY OF THE FOLLOWING, PLEASE EXPLAIN ANY YES ANSWER:

Preterm labor _____ YES _____NO _____

Substance abuse _____ YES _____NO _____

Emotional problems _____ YES _____NO _____

Medications _____ YES _____NO _____

Medical problems _____ YES _____NO _____

HOW MANY WEEKS GESTATION WAS THE PREGNANCY? _____ Weeks, _____Term, _____ Preterm

WAS THE DELIVERY (CHECK ALL THAT APPLY): _____ Vaginal _____C-Section _____ Induced

_____Spontaneous _____ Scheduled _____Emergent

ANY DELIVERY COMPLICATIONS? _____ YES _____NO. If yes, please explain: _____

_____

DEVELOPMENTAL HISTORY:

WERE EARLY CHILDHOOD DEVELOPMENTAL MILESTONES (SIT, WALK, TALK, TOILET TRAIN, ETC)?

_____Early _____On time _____Late

PLEASE LIST ANY DEVELOPMENTAL CONCERNS ABOUT YOUR CHILD: _____

_____

_____

PAST MEDICAL HISTORY:

HAS YOUR CHILD EVER HAD? _____ Headaches _____Seizures _____ Allergies (seasonal)

_____Diabetes _____ Thyroid condition _____Asthma _____ Other lung problems _____Cancer

_____ Head injury/concussion _____OTHER:_____

_____

HAS YOUR CHILD EVER HAD ANY SURGERIES? _____ YES _____NO If yes, please list surgeries and dates:

_____

_____

_____

_____

CURRENT MEDICATIONS

Name	Dosage	Frequency	When started

MEDICATION ALLERGIES _____ NONE _____YES (please explain) _____

_____

OTHER ALLERGIES _____ NONE _____YES (please explain) _____

_____

BIOLOGICAL FEMALES ONLY: HAS YOUR CHILD STARTED MENSTRUATION? _____ YES _____NO

IF YES, AT WHAT AGE _____

ARE PERIODS REGULAR? _____ YES _____NO DATE OF LAST MENSTRUAL CYCLE ____ / ____ / _____

IS THERE ANY CHANGE IN SYMPTOM SEVERITY WITH PERIODS? _____ YES _____NO

IF YES, PLEASE DESCRIBE_____

PAST PSYCHIATRIC HISTORY:

HAS YOUR CHILD EVER SEEN A PSYCHIATRIST OR THERAPIST/COUNSELOR BEFORE? ____ YES _____NO

Name of provider Dates seen Reason

_____

_____

_____

_____

HAS YOUR CHILD EVER BEEN ADMITTED TO A PSYCHIATRIC HOSPITAL? _____ YES _____NO

Name of the hospital Dates Reason

_____

_____

_____

_____

HAS YOUR CHILD EVER ATTEMPTED SUICIDE? _____ YES _____NO If yes, please describe: _____

_____

_____

DOES YOUR CHILD ENGAGE IN ANY SELF-HARM BEHAVIORS (LIKE CUTTING)? _____ YES _____NO

If yes, please describe: _____

_____

_____

HAS YOUR CHILD EVER BEEN VIOLENT OR AGGRESSIVE? _____ YES _____NO

If yes, please describe: _____

_____

_____

HAS YOUR CHILD EVERY USED ANY OF THE FOLLOWING? (MARK ALL THAT APPLY)

_____Tobacco _____Vaping _____Marijuana _____Alcohol

_____Opiates _____Benzos _____Ecstasy _____Methamphetamine

_____Cocaine _____Heroin _____Other:_____

IS YOUR CHILD CURRENTLY USING ANY OF THOSE MARKED ABOVE? _____Yes _____No

PLEASE MARK ANY PSYCHIATRIC MEDICATIONS YOUR CHILD HAS TAKEN IN THE PAST:

_____Alprazolam (Xanax) _____Diazepam (Valium) _____Mirtazapine (Remeron)

_____Amitriptyline (Elavil) _____Duloxetine (Cymbalta) _____Nortriptyline (Pamelor)

_____Amphetamine (Adderall) _____Escitalopram (Lexapro) _____Olanzapine (Zyprexa)

_____Aripiprazole (Abilify) _____Fluoxetine (Prozac) _____Oxcarbazepine (Trileptal)

_____Asenapine (Saphris) _____Fluphenazine (Prolixin) _____Paliperidone (Invega)

_____Atomoxetine (Strattera) _____Fluvoxamine (Luvox) _____Paroxetine (Paxil)

_____Bupropion (Wellbutrin) _____Guanfacine (Intuniv) _____Quetiapine (Seroquel)

_____Buspirone (BuSpar) _____Haloperidol (Haldol) _____Risperidone (Risperdal)

_____Carbamazepine (Tegretol) _____Iloperidone (Fanapt) _____Sertraline (Zoloft)

_____Citalopram (Celexa) _____Imipramine (Tofranil) _____Topiramate (Topamax)

_____Clomipramine (Anafranil) _____Lamotrigine (Lamictal) _____Trazodone (Desyrel)

_____Clonazepam (Klonopin) _____Levomilnacipran (Fetzima) _____Valproic Acid (Depakote)

_____Clonidine (Kapvay) _____Lisdexamfetamine (Vyvanse) _____Venlafaxine (Effexor)

_____Clozapine (Clozaril) _____Lithium _____Vilazodone (Viibryd) _____Desipramine (Norpramin)

_____Lorazepam (Ativan) _____Vortioxetine (Brintellix) _____Desvenlafaxine (Pristiq)

_____Loxapine (Loxitane) _____Ziprasidone (Geodon) _____Dexmethylphenidate (Focalin)

_____Lurasidone (Latuda) _____ Other: _____

FAMILY MEDICAL HISTORY including great grandparents, grandparents, parents, great aunts, great uncles, aunts, uncles, cousins of any degree, siblings, nieces, nephews, etc.

Have any of your child's relatives ever had any of the following:

	Yes	No	Relationship to child
Migraine/Chronic headaches			
Seizures			
Stroke			
High blood pressure			
Heart disease			
Heart attack			
Heart Murmur			
Lung disease			
Asthma			
Gastric reflux disease			
Diabetes			
High cholesterol			
Liver disease			
Kidney disease			
Thyroid disease			
Obesity			
Glaucoma			
Anemia			
Sudden unexplained death			
Dementia			
Cancer			

FAMILY PSYCHIATRIC HISTORY

Have any of your child's blood relatives ever had any of the following:

	Yes	No	Relationship to child
Depression			
Bipolar disorder			
Suicide			
Anxiety disorders			
Panic disorder			
Agoraphobia			
Obsessive Compulsive Disorder			
PTSD			
Eating disorder			
Schizophrenia			
Other psychosis			
ADHD/ADD			
Oppositional Defiant Disorder			
Conduct disorder			
Personality disorders			
Tourette's syndrome			
Autism spectrum disorder			
Alcoholism			
Substance abuse			
Psychiatric hospitalizations			

_____

Signature of person completing form Date