Child Psychiatry Intake Questionnaire

In order for us to be able to fully evaluate your child, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to; do the best you can. Thank you!

Patient Information:
Last Name:_____ First Name: _____ MI _____
Nickname: _____ Sex: ☐ Male ☐ Female
Address: _____ City: _____
State: _____ Zip: _____
Mobile Phone: _____ Home Phone: _____Work Phone: _____
Home e-Mail: _____
Parent's Name: _____
Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed

Referred by:
Last Name: _____ First Name: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Fax: _____

History:
Purpose of Consultation / Chief Complaint:

_____
_____
_____
_____
_____
_____

How long have these difficulties been present?

_____
_____
_____
_____
_____
_____
_____
_____

Current Medications: Date Prescribed:

_____
_____
_____
_____

Drug Allergies:_____
_____

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Child's Developmental History:
Prenatal Events:
Parent's Conception: ☐ Planned ☐ Unplanned
Pregnancy complications (bleeding, excess-vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc.)_____
_____
Birth and Postnatal Period:
Birth weight:_____ Length:_____ Labor Duration:_____
Delivery: Vaginal:_____ C-section:_____ Problems:_____
ApGAR scores (if known)_____ Jaundice: □ Yes □ No
Time in hospital_____
Any other complications:_____
Mother's Health after Delivery:
Post delivery blues? Yes No If yes, how long?_____
Primary caretaker for child, first year _____thereafter_____
Feeding history: Breast Bottle_____age weaned_____
Food allergies:_____
Current eating problems_____
_____
Sleep Behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)_____
_____
Separation from mother and/or father: age, duration, reaction to_____
_____

Motor Development:
Please write in age. (Parentheses are approximate normal limits)
_____ Rolls over (3-5 months) _____ Sit without support (5-7 months) _____ Crawls (5-8 mos)
_____ Walks well (11-16 months) _____ Runs Well (2 yr) _____ Rides Tricycle(3 yrs)
_____ Throws ball overhand (4yr)
Fine and gross motor coordination compared to peers _____
Any current problems: _____
Language Development:
_____ Several words besides dada, mama (1 yr)
_____ 3 words together, subject, verb, object (24 month)
_____ Name several objects-ball, cup (15 months)
Vocabulary, Articulation & Comprehension compared to peers _____
Any current problems: _____
Social Development:
_____smile (2mo) _____shy with strangers (6-10mos) _____separate from mother easily (2-3yr)
_____cooperative play with other (4yr)
Quality of early peer interactions _____
Current peer interactions _____
_____
Special interests _____
_____
Relationships to family members _____

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Toilet Training:
Age reached bowel control: _____ day _____ night
Age reached bladder control: _____ day _____ night
Methods used: _____
Ease: _____
Current function: _____

Sexual development:
Gender identity_____
Any problems_____

Behavioral/discipline:
Compliance vs. non-compliance: _____
Lying/stealing: _____
Rule Breaking: _____
Methods of discipline:_____
Other problems: _____

Emotional Development:
Early Temperament_____
Current Personality _____
Mood _____
Habits _____
Fears/phobias_____
Special objects (blankets, dolls, etc) _____
Ability to express feelings _____

School History:
Current Grade_____
School contact_____
Number of schools attended _____ Average grades_____
Homework problems_____
Specific learning disabilities?_____
Strengths?_____
_____
What have teachers said about the child/teen_____
_____
_____
Overall strengths as viewed by parents_____
_____
_____
Overall strengths as viewed by the child or teen_____
_____
_____

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MEDICAL HISTORY

Prior Surgeries/Hospitalizations:

Date	Reason	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other doctors/clinics seen regularly:_____

_____

_____

_____

Any history of head trauma OR loss of consciousness? (describe):_____

_____

_____

Any periods of extreme spaciness or confusion? (describe):_____

_____

Prior tests, note if abnormal (EEG, QEEG, MRI, CT etc):_____

_____

Allergies/drug intolerances (describe):_____

_____

Your daughter's: Onset of Menses _____ Last Menstrual Period_____

Sexually Active Yes No Birth Control Method _____

Number of pregnancies: _____ Number of live births: _____

MEDICAL HISTORY

Has your child ever had:

□ Headache Migraine □ CNS Malignancy
□ Kidney disease
□ Headache/ Tension □ Depression
□ Sexually transmitted disease
□ Epilepsy/Seizures □ Coronary Artery Disease □ Shortness of breath
□ Cerebro Vascular □ Diabetes
□ Chemical/ Exposure
□ Other Neuromuscular □ Arthritis
□ Tuberculosis/disorder
□ Head Injury □ MI □ HIV
□ Spinal cord injury □ Arrhythmias
□ Hepatitis
□ Cervical Spine disease
□ Congestive Heart Failure □ Skin disorders
□ Lumbar spine injury
□ Anemia □ Cataracts
□ Peripheral nerve □ Murmur
□ Thyroid disease
□ Cancer □ Pneumonia □ Venereal Disease
□ Hypertension □ Dizzy spells □ COPD
□ Heart Attack □ Cancer □ Smoking
□ Stroke □ Mumps □ Drug use
□ Measles □ Polio □ Rheumatic Fever
□ Allergy/Hay Fever
□ Genitourinary disease
□ Peripheral vascular disease
□ Depression □ Other endocrine □ Other

Please explain all those checked:_____

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Review of Systems:
□ Fatigue □ Cardiac □ Genitourinary
□ Weight Loss □ Respiratory □ Musculoskeletal
□ Fevers □ Peripheral Vascular □ Dermatologic
□ Depression □ Gastrointestinal □ Hematologic
□ Ear/Nose/Throat □ Other
Please explain all checked items: _____
_____

Medical History
Review of Systems- Neurological:
□ Headache □ Blurred vision □ Weakness-arms
□ Dizziness □ Diplopia □ Weakness-legs
□ Syncope □ Amaurosis □ Numbness-arms
□ Confusion □ Other visual changes □ Numbness-legs
□ Concentration □ Difficulty chewing □ Paresthesia
□ Memory □ Facial numbness/tingling □ Stiffness
□ Lethargy □ Drooling □ Clumsiness
□ Personality Change □ Difficulty Tasting □ Pain
□ Hallucinations □ Tinnitus □ Poor balance
□ Speech difficulty □ Vertigo □ Poor coordination
□ Spells □ Decreased hearing R/L □ Trouble walking
□ Nausea □ Dysphasia □ Incontinence-bladder
□ Vomiting □ Hoarseness □ Incontinence-bowel
□ Trouble with Smell □ Choking □ Other
Please explain all checked items:_____
_____

Psychiatric History
Has your child ever been hospitalized for a psychiatric illness?
□ Yes □ No If yes; when, where, and for what?_____
_____
_____

Has your child been in any outpatient therapy, counseling, or had any psychiatric or psychological evaluations?
□ Yes □ No If yes: when, with whom, and for what?_____
_____
_____

If medication has been prescribed for your child, please list below:

Medication	Prescribing Doctor	Dates	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Drug/Alcohol History

Has your child ever used alcohol or drugs? □ Yes □ No If yes, what does he or she use?

Drug / alcohol	Frequency of use	Amount	Length of use	Last used

Has your child ever experienced withdrawal symptoms from alcohol or drugs? □ Yes □ No
If yes, please explain. _____

Has anyone told you/your child they thought he or she had a problem with drugs or alcohol?
□ Yes □ No If yes, please explain._____

Has your child ever felt guilty about his or her drug or alcohol use?□ Yes □ No
If yes, please explain._____

Has your child ever felt annoyed when someone talked to them about their drug or alcohol use?
□ Yes □ No If yes, please explain._____

Has your child ever used drugs or alcohol first thing in the morning? □ Yes □ No
If yes, please explain. _____

Cigarette use? □ Yes □ No If yes, how much? _____
Caffeine use? □ Yes □ No If yes, how much? _____

Abuse History

Has your child been a victim of:
Physical abuse □ Yes □ No
Emotional abuse □ Yes □ No
Sexual abuse? □ Yes □ No
Other traumatic event □ Yes □ No
If yes, please explain:_____

Legal History

Has your child been in trouble with the law? □ Yes □ No_____

What were the consequences (e.g. court, probation, detention, community service)?_____

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Family History
Current Family Structure (who does your child currently live with; cultural/ethnic background, religious practices etc.):_____
_____
_____
Household Occupants: (Names, ages, medical/psychological issues)_____
_____
_____
_____
Household Stressors: (Include financial, legal, illness, bereavement, divorce, blended family issues etc.)_____
_____
_____
_____

If Adopted - Biological Mother's History: If yes: Age ___
__ Highest Grade Completed_____ Occupation_____
Learning Problems □ Yes □ No _____
Behavior Problems □ Yes □ No _____
Marriages □ Yes □ No _____
Medical Problems □ Yes □ No _____
Childhood Atmosphere (family position, abuse, illness)_____
Alcohol/Drug Abuse History □ Yes □ No _____
Have any of biological mother's blood relatives ever had any learning or psychiatric including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify):_____
_____

Biological Father's History:
If yes: Age _____ Highest Grade Completed _____ Occupation _____
Learning Problems □ Yes □ No _____
Behavior Problems □ Yes □ No _____
Marriages □ Yes □ No _____
Medical Problems □ Yes □ No _____
Childhood Atmosphere (family position, abuse, illness) _____
Alcohol/Drug Abuse History □ Yes □ No _____
Have any of the biological father's blood relatives ever had any learning or psychiatric problems? (specify, as above):_____
_____

Biological Siblings's History:
If yes: Age(s) ____ Highest Grade(s) Completed _____
Learning Problems □ Yes □ No _____
Behavior Problems □ Yes □ No _____
Medical Problems □ Yes □ No _____
Alcohol/Drug Abuse History □ Yes □ No _____
Have any of the biological father's blood relatives ever had any learning or psychiatric problems? (specify as above):_____
_____