**CHILD AND ADOLESCENT MENTAL HEALTH FORM**

Instructions:

1. Please complete as much as you can, all information is good information. Completion of this form is required for an intake to be scheduled, and a new patient cannot be seen without it.
2. If the guardian is not a biological parent, legal custody documentation MUST be brought to our office before the child can be seen. NO EXCEPTIONS.
3. Any information that is not known should be answered with "unknown" or "not applicable". Identical information does not need to be repeated (addresses, etc.).
4. Any additional information may be written on the bottom of the form.
5. Please bring any reports from teachers and/or school testing (IEP/504plan reports, etc.) to the first appointment.
6. Please ask our front desk staff or call our office if you have any questions. Thank you.

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| **Name of Minor:** | Click or tap here to enter text. | **DOB**: | Click or tap here to enter text. |
| **Name of Legal Guardian:** | Click or tap here to enter text. | **Guardian Phone #:** | Click or tap here to enter text. |
| **Are you being referred to the MH Clinic? By who? (Answer below)** |[ ]  Yes |[ ]  No |
| Click or tap here to enter text. |
| **For what reason was the minor referred or the reason you are seeking assistance? (Answer Below)** |
| Click or tap here to enter text. |

\*\*If you are not the natural parent please provide the clinic your court ordered guardianship documents.
\*\*If the minor is being referred please bring all paperwork from referring agencies.

**FAMILY DATA:**

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| **Mother’s Name:** | Click or tap here to enter text. | **Mother’s DOB:** | Click or tap here to enter text. |
| **Is mother:** | [ ] Natural Parent | [ ] Stepmother | [ ] Grandparent | [ ] Auntie | [ ] Other relation (Specify Below) |
| Click or tap here to enter text. |
| **Phone number:** | Click or tap here to enter text. | **Do you live in home with patient?** | [ ] Yes | [ ] No |

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| **Father’s Name:** | Click or tap here to enter text. | **Father’s DOB:** | Click or tap here to enter text. |
| **Is Father:** | [ ] Natural Parent | [ ] Stepfather | [ ] Grandparent | [ ] Uncle | [ ] Other relation (Specify Below) |
| Click or tap here to enter text. |
| **Phone number:** | Click or tap here to enter text. | **Do you live in home with patient?** | [ ] Yes | [ ] No |

\*\*If you are adopted guardian, please complete Natural parent information below:

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| **Does the patient have siblings? (Please list below)** | [ ] Yes | [ ] No |
| **Name and Age:** | Click or tap here to enter text. | [ ] M [ ] F | [ ] Full [ ] Half [ ] Step [ ] Adopted |
| **Any other adults or children living in the home with patient? (Please list below)** | [ ] Yes | [ ] No |
| **Name and Age:** | Click or tap here to enter text. | [ ] M [ ] F | [ ] Full [ ] Half [ ] Step [ ] Adopted |
| **Living with patient?** | [ ] Yes | [ ] No |
| **Name and Age:** | Click or tap here to enter text. | [ ] M [ ] F | [ ] Full [ ] Half [ ] Step [ ] Adopted |
| **Living with patient?** | [ ] Yes | [ ] No |
| **Name and Age:** | Click or tap here to enter text. | [ ] M [ ] F | [ ] Full [ ] Half [ ] Step [ ] Adopted |
| **Living with patient?** | [ ] Yes | [ ] No |

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| **Does anyone else live in the household? (Please list below)** | [ ] Yes | [ ] No |
| **Name and Age:** | Click or tap here to enter text. | [ ] M [ ] F | Relation | Click or tap here to enter text. |
| **Name and Age:** | Click or tap here to enter text. | [ ] M [ ] F | Relation | Click or tap here to enter text. |
| **Name and Age:** | Click or tap here to enter text. | [ ] M [ ] F | Relation | Click or tap here to enter text. |
| **Name and Age:** | Click or tap here to enter text. | [ ] M [ ] F | Relation | Click or tap here to enter text. |

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| **How long has the patient lived at the current home?** | Click or tap here to enter text. |
| **Does the patient have their own room?** |[ ]  Yes |[ ]  No |
| **Does the patient have their own bed?** |[ ]  Yes |[ ]  No |
| **Does the home have running water?** |[ ]  Yes |[ ]  No |

**DEVELOPMENTAL INFORMATION****:**

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| **Length of Pregnancy:** | [ ] Full Term | [ ] Premature | [ ] Other (Specify) | Click or tap here to enter text. |
| **Birth Weight:** | Click or tap here to enter text. | Any complications? | Click or tap here to enter text. |
| **Did mom experience any of the following during or shortly after birth?:** | [ ] Depression | [ ] Anxiety |
| **Nature of delivery:**  | [ ] Natural | [ ] Caesarian | [ ] Breech |
| **Condition of child at birth:** | [ ] Normal | [ ] Other (Specify): | Click or tap here to enter text. |
| **During Pregnancy were any of the following used (Specify below):**  |
| [ ] Medication [ ] Alcohol [ ] Drugs [ ] Other:  | Click or tap here to enter text. |
| **How old was the child when he/she started crawling?** | Click or tap here to enter text. |
| **How old was the child when he/she started walking?** | Click or tap here to enter text. |
| **How old was the child when he/she started talking?** | Click or tap here to enter text. |
| **How old was the child when he/she started using the toilet?** | Click or tap here to enter text. |
| **Was/Is the child consolable?**  | [ ] Yes [ ] No |
| **Did the child like to be held?** | [ ] Yes [ ] No |
| **Did the child feed easily?**  | [ ] Yes [ ] No |
| **Was the child adopted? (Please explain situation below)** | [ ] Yes [ ] No |
| Click or tap here to enter text. |

**EDUCATION HISTORY**

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| **Name of current school:** | Click or tap here to enter text. | **Current grade:** | Click or tap here to enter text. |
| **If the child is not currently enrolled please answer the questions below:** |
| **Name of Last school:** | Click or tap here to enter text. | **Last grade completed:** | Click or tap here to enter text. |
| **Date withdrawn:** | Click or tap here to enter text. | **Reason for withdrawal:** | Click or tap here to enter text. |
| **Has the child repeated any grades?** | [ ] Yes [ ] No |
| **Does the child have a IEP or 504 plan with school?** | [ ] Yes [ ] No |
| **Is the child in special education?** | [ ] Yes [ ] No |
| **Does the child have an emotional support plan with school?** | [ ] Yes [ ] No |
| **Please explain the plan if any:** | Click or tap here to enter text. |
| **Does the child require:** | [ ] Speech Therapy [ ] Occupational Therapy [ ] One:One learning |

**Please check the items below that you feel pertain to your child:**

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|[ ]  Often fails to finish things |
|[ ]  Easily distracted |
|[ ]  Has difficulty concentrating |
|[ ]  Shifts excessively from one activity to another |
|[ ]  Daydreams or gets lost in his/her thoughts |
|[ ]  Frequently disruptive in class |
|[ ]  Has difficulty awaiting his/her turn (i.e. games) |
|[ ]  Has difficulty sitting still |
|[ ]  Impulsive or acts without thinking |

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|[ ]  Poor relationship with parents |
|[ ]  Severe temper tantrums, outbursts |
|[ ]  Negative peers - hangs with others that get in trouble |
|[ ]  Argues a lot, bragging, boasting |
|[ ]  Mean to others |
|[ ]  Running away  |
|[ ]  Lying |
|[ ]  Will not follow limits set by parents |
|[ ]  Abusive to animals |
|[ ]  Property destruction (i.e. vandalism, destructive) |
|[ ]  Physically abusive to self (scratches self, cuts, hair pulling) |
|[ ]  Fire setting |
|[ ]  Stealing, Shoplifting, Breaking and Entering |
|[ ]  Drug Abuse (explain) | Click or tap here to enter text. |
|[ ]  Alcohol Abuse (explain) | Click or tap here to enter text. |
|[ ]  Any involvement with juvenile court (explain) | Click or tap here to enter text. |
|[ ]  Has attempted suicide (Explain) | Click or tap here to enter text. |

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|[ ]  Unrealistic fears (explain) | Click or tap here to enter text. |
|[ ]  Acts too young for his/her age |
|[ ]  Clings to adults or too dependent |
|[ ]  Feels no one loves him/her |
|[ ]  Gets teased a lot |
|[ ]  Complains of loneliness |
|[ ]  Demands a lot of attention |
|[ ]  Easily made jealous  |
|[ ]  Refusal to attend school |
|[ ]  Avoids being left alone |
|[ ]  Excessive need for reassurance |
|[ ]  Very self-conscious or easily embarrassed |
|[ ]  Often appears tense and unable to relax  |
|[ ]  Frequent physical complaints (i.e. headaches, stomach aches, nausea) |
|[ ]  Overly concerned with future events |
|[ ]  Nervous mannerisms (i.e. nail biting, thumb sucking, rocking) |
|[ ]  Feelings of inadequacy |
|[ ]  Refuses to speak in certain situations |

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|[ ]  Panic – feelings of intense fear/discomfort with palpitations, tremors, shortness of breath,choking feelings, etc.  |
|[ ]  Obsessions – unwanted ideas, images or impulses that intrude on thinking against your wishesand efforts to resist them. (Fear of contamination, extreme concern with order, symmetry or exactness).  |
|[ ]  Can’t get his/her mind off certain thoughts  |
|[ ]  Fears he/she may do something bad |
|[ ]  Fears she/he has to be perfect |

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|[ ]  Strange thoughts or ideas (Explain) | Click or tap here to enter text. |
|[ ]  Hallucinations (Describe) | Click or tap here to enter text. |
|[ ]  Inappropriate expression of feelings (i.e. laughing at something sad) |
|[ ]  Poor personal hygiene (not bathing for days, no interest in appearance) |
|[ ]  Concern that others are watching them, following them, and/or “out to get them” |

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|[ ]  Severe mood changes (i.e. very sad to very happy) |
|[ ]  Often appears sad |
|[ ]  Confused or seems to be in a fog  |
|[ ]  Decreased energy |
|[ ]  Social withdrawal |
|[ ]  Overtired/fatigue |
|[ ]  Negative outlook toward the future |
|[ ]  Excessive tearfulness or crying |
|[ ]  Underactive, slow-moving, lethargic |
|[ ]  Recurrent thoughts about death or preoccupation with death |
|[ ]  Suicidal thoughts or statements (Explain) | Click or tap here to enter text. |
|[ ]  Sleep difficulties |
|[ ]  Eating difficulties |

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|[ ]  Has difficulty making or keeping friends |
|[ ]  Does not associate with people his/her own age |
|[ ]  Avoids unfamiliar social situations |
|[ ]  Changes in schedule are difficult |
|[ ]  Need for high degree of supervision |
|[ ]  Low frustration tolerance, irritability |
|[ ]  Preoccupied with a specific person/character or object |
|[ ]  Very sensitive to textures, sounds, and/or smells |
|[ ]  Delayed or absent speech |
|[ ]  Preoccupied with parts of objects |
|[ ]  Enuretic (urinates during the day or night on self) |
|[ ]  Deliberately harms self |
|[ ]  Uncoordinated, accident-prone |
|[ ]  Tics (sudden rapid, recurrent movements or sounds) |
|[ ]  Encopretic (soils self) |

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|[ ]  Concerns about sexual identity |
|[ ]  Sexually promiscuous |
|[ ]  Inappropriate sexual behavior (Explain) |

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| **Have there been any significant stressors or traumas to the family and child? Explain.** | [ ] Yes [ ] No |
| Click or tap here to enter text. |

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| **Has this child ever been exposed to abuse (physical, sexual, and/or emotional)?**  | [ ] Yes [ ] No |
| Click or tap here to enter text. |
| **If so, has CPS been notified? Please explain:** | [ ] Yes [ ] No |
| Click or tap here to enter text. |

**PSYCHIATRIC/PSYCHOLOGICAL/MEDICAL**

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| **Has your child seen a Mental Health professional in the past ? (If Yes, please list below)** | [ ] Yes | [ ] No |
| **Psychiatrist** | Click or tap here to enter text. |
| **Therapist** | Click or tap here to enter text. |
| **Who is your pediatrician for the patient?** | Click or tap here to enter text. |

**Medications:**

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| **Has the patient been on any Mood or Behavioral medications in the past? (Please list)** | [ ] Yes | [ ] No |
| **Name of medication** | **Dose** | **Reason** | **Reason stopped** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

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| **Is the patient on any current medications? Please list all medications below and reason:** | [ ] Yes | [ ] No |
| **Name of Medication** | **Dose** | **Reason** | **Do you think it is helping?** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | [ ] Yes | [ ] No |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | [ ] Yes | [ ] No |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | [ ] Yes | [ ] No |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | [ ] Yes | [ ] No |

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| **Does the patient have any medication allergies? (Please list below)** | [ ] Yes | [ ] No |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

**Psychiatric/Medical History:**

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| **Has your child ever been hospitalized for Mental Health reasons? (Please explain below)** | [ ] Yes | [ ] No |
| **Name of facility:** | Click or tap here to enter text. | **Dates of admission:**  | Click or tap here to enter text. |
| **Reason for Admission:** |  |
| **Has your child ever been hospitalized for Mental Health reasons? (Please explain below)** | [ ] Yes | [ ] No |
| **Name of facility:** | Click or tap here to enter text. | **Dates of admission:** | Click or tap here to enter text. |
| **Reason for Admission:** |  |

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| **Please check if any of the following**  |
|[ ]  Heart Murmur |[ ]  Heart Condition |[ ]  Nausea/Vomiting |[ ]  Diarrhea |
|[ ]  Concussion |[ ]  Seizures |[ ]  Fainting |[ ]  Lung Disease |
|[ ]  Jaundice |[ ]  Diabetes |[ ]  High Fevers |[ ]  Asthma |
|[ ]  Liver Disease |[ ]  Dietary Problems |[ ]  Skin Disease |[ ]  Major Surgeries |
|[ ]  Hearing Problems |[ ]  Vision Problems |[ ]  Speech Issues |[ ]   |
|[ ]  Urinary Problems |[ ]  Bowel/Stomach Problems |[ ]  Other: (Explain blow) |
|[ ]  Activity Limitations |  | Click or tap here to enter text. |

**Diet and Activity:**

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| **Is the patient active or exercise regularly?** | [ ] Yes | [ ] No |
| **How many servings does the patient have regularly: (See below)** |
| **Fruits:** | Click or tap here to enter text. | **Veggies:** | Click or tap here to enter text. |
| **Fast Food:** | Click or tap here to enter text. | **Soda:** | Click or tap here to enter text. |
| **How many hours daily does the patient spend on the following:** |
| **Phone/Tablet** | Click or tap here to enter text. | **TV:** | Click or tap here to enter text. |
| **Video Games:** | Click or tap here to enter text. | **Social Media:** | Click or tap here to enter text. |

**FAMILY MEDICAL/PSYCHIATRIC HISTORY**

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| **Please list any conditions that apply to your child’s blood relatives (example: depression, anxiety, panic attacks, psychosis, bipolar disorder, alcohol abuse, other substance use, suicide attempt, etc.; Medical: heart condition, sudden death, seizures, etc.).**  |
| **Mother:** | Click or tap here to enter text. |
| **Father:** | Click or tap here to enter text. |
| **Brothers:** | Click or tap here to enter text. |
| **Sisters:** | Click or tap here to enter text. |
| **Grandparents:**  | Click or tap here to enter text. |

~END OF QUESTIONNAIRE, THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM~

This section of any additional information that you wish to share.

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| Click or tap here to enter text. |