Center for Integrative Psychology

Child/Teen Intake Questionnaire

Parents-In order for me to be able to fully evaluate your child or teenager, please fill out the following intake form and questionnaires to the best of your ability. I realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your child or teenager's medical chart it is ok to refrain from putting it on this form. If a question does not apply to your child mark it N/A. Thank you!

PATIENT IDENTIFICATION

Patient Name _____ Nickname_____ First Appointment Date: _____

Birth Date _____ Age _____ Sex _____ Race _____

School _____ Grade _____ Special Ed: Yes No Certification Type: _____

Biological Mother _____Date of Birth: _____Religion _____Race _____

Mother's Employer: _____ Is the child covered under that insurance? Yes No

Biological Father _____Date of Birth: _____Religion:_____Race: _____

Father's Employer: _____ Is the child covered under that insurance? Yes No

The legal address of the child, and information about who lives in that home:

Address: _____

City _____ State _____ Zip _____

Please only list the numbers you want me to call you where I can feel free to leave a message identifying myself as Dr. Jay.

Home Phone: _____ Any Other important contact number:_____

Mother's Work: _____ Mother's Cell: _____ Mother's email: _____

Father's Work: _____ Father's Cell: _____ Father's email: _____

Minor's Cell: _____ Minor's email: _____

List all the people the child is currently living with at the home listed above: (use the back of this sheet if necessary)

Person Date of Birth Relationship to patient Comment

_____

_____

_____

Have the biological parents been divorced? Yes No Date of divorce: _____ Age of child at that time: _____

Do both parents have legal custody? Yes No Details: _____

Do the natural parents share joint physical custody or does one have sole physical custody? _____

What percentage of uninsured medical expenses does the judgment of divorce say that you are responsible for? _____

Has the child been legally adopted? Yes No by whom?_____

Does anyone else have legal or physical custody? Yes No Details: _____

The address of the other parent and information about who lives in that home:

Address: _____

City _____ State _____ Zip _____

Please only list the numbers you want our staff to call you where we can feel free to leave a message identifying ourselves as mental health professionals:

Home Phone: _____ Any Other important contact number:_____

Mother's Work: _____ Mother's Cell: _____ Mother's email: _____

Father's Work: _____ Father's Cell: _____ Father's email: _____

Minor's Cell: _____ Minor's email: _____

List all the people the child is currently living with at the home listed above: (use the back of this sheet if necessary)

Person Date of Birth Relationship to patient Comment

_____
_____
_____
_____
_____
_____

Who referred you to CIP? _____

Referral Address_____

Referral City and Zip _____

Phone # _____

Do I have your permission to release information to the referring professional when it is appropriate?

Yes No

MAIN PURPOSE OF THE CONSULTATION (please give a brief summary of the main problems)

_____

_____

_____

What lead you to seek evaluation and treatment at this time?

_____

_____

_____

What do you want CIP to do for your child, yourself or your family?

_____

_____

_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY (Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

_____

Current medical problems: _____

Past medical problems: _____

Other doctors/clinics seen regularly:

Any history of hitting their head or head trauma? (describe): _____

Ever any seizures or seizure like activity? _____

Any periods of spaciness or confusion? _____

Prior hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc.: _____

Allergies/drug intolerances (describe): _____ _____

Child's Present Height _____ Present Weight _____

Do you have a carbon monoxide detector in your home? Yes No

Do you have mold in your basement? Yes No

Does your child have silver amalgam dental fillings? Yes No

Current Stresses (please list current factors that are a source of stress in the family) _____

_____

_____

FAMILY STORY

Family Structure-describe the emotional tone in the current household with the child, and the relationship between the parents and other family members: _____

_____

Current Marital Situation/Satisfaction of Parents:
_____

_____

Family History (include marriages, separations, divorces, deaths, traumatic events, losses, etc.) _____

_____

_____

Biological Mother's History: Her age when child born _____

Does mother work outside the home? Yes No Describe Job and hours:
_____

_____

School: highest grade completed: _____

Learning problems (specify): _____

Behavior problems (specify): _____

Marriages: _____

Medical Problems: _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has mother ever sought psychiatric treatment? Yes No

If yes, for what purpose? _____ _____

Mother's alcohol/drug use history _____ _____

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, bipolar disorder, anxiety, suicide attempt, psychiatric hospitalizations?

(specify) _____

_____

_____

_____

Biological Father's History: His Age when child born _____ does father work outside the home? Yes No

Describe Job and hours: _____

_____

School: highest grade completed _____ _

Learning problems (specify) _____ _

Behavior problems (specify) _____ _

Marriages _____

Medical Problems _____

Childhood atmosphere (family position. abuse. illnesses. etc) _____

_____

Has father ever sought psychiatric treatment? Yes No

If yes, for what purpose? _____ _

Father's alcohol/drug use history _____ _

Have any of father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, bipolar disorder, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

(If Applicable)

Step or Adopted Mother's History (indicate which): Date of Birth: _____ outside work _____ _

School: highest grade completed _____ _

Learning problems (specify) _____ _

Behavior problems (specify) _____

Marriages _____ _

Medical Problems _____ _

Childhood atmosphere (family position, abuse. illnesses. etc) _____ _

Has step-mother ever sought psychiatric treatment? Yes _ No _

If yes, for what purpose? _____ _

Step or adopted mother's alcohol/drug use history _____ _

Step or Adopted Father's History (Indicate which): Date of Birth: _____ His Age when child born _____

Does stepfather work outside the home? _____

School: highest grade completed: _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems_____

Childhood atmosphere (family position. abuse, illnesses. etc) _____

_____

Has step or adopted father ever sought psychiatric treatment? Yes No

If yes, for what purpose? _____

Step or adopted father's alcohol/drug use history _____ _

Siblings: (names, ages, problems, strengths, relationship to patient)

_____

_____

_____

_____

_____

CHILD'S DEVELOPMENTAL HISTORY

Significant Prenatal events: _____

Parents attitude toward pregnancy _____

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol, drug use,

etc _____

How active was the baby when you carried it: Very active: _____ Average _____ Minimally _____

Birth and Postnatal period:

Birth weight _____ Length _____ Labor duration _____ Delivery: vaginal ___ C section ____

Problems: _____

APGAR scores (if known) _____ _____Any jaundice? Yes __ No __ Time in hospital _____ _

Complications? _____ _____ _

Mother's health after delivery: _____

Post delivery blues? _____ if yes, how long? _____

Who was the primary caretaker for child, first year _____ _

thereafter _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

Separation problems from mother and/or father: age, duration, reaction to _____ _

Physical/Sexual Abuse: _____

_____

Motor development: (please indicate if there were lags in normal motor movements) Yes No

Describe: _____

Language development: (please indicate if there were lags in verbal skills) Yes No

Describe: _____

Social development: (please write in age, parentheses are the approximate normal limits)

quality of attachment to mother _____ quality of attachment to father
quality of relationships to family members _____

early peer interactions _____ _____

current peer interactions _____ _____

special interests/hobbies _____ _____

Drug/Alcohol History: _____

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: _____

_____

Please bring school report cards and any state, national or special testing that has been performed.

Sleep behavior:

Is it hard for your child to go to bed? Yes No Explain: _____
How long does it take them to fall asleep? _____
Once they fall asleep do they stay asleep? Yes No
Do they snore? Yes No
How many hours of sleep do they usually get? _____

Do they have sleepwalking, nightmares, night terrors, recurrent dreams, restless legs, talking in their sleep:
_____
_____

Overall Strengths - as viewed by parents _____

_____

Overall Strengths -- as viewed by the child/teen _____

_____

Is there anything else you want us to know? _____

_____

_____

_____

Pediatrician: _____

Address: _____

_____

_____

Phone: _____

Psychiatrist: _____

Address: _____

_____

_____

Phone: _____

Other Physicians with their phone number:

_____

_____

List all medications you are taking and their dosage:

_____ prescribed by: _____

_____ prescribed by: _____

_____ prescribed by: _____

_____ prescribed by: _____

_____ prescribed by: _____

List supplements you are taking:

_____

_____

_____

_____

Primary Insurance Information:

Insurance Company name: _____
Policy Number or Contract # _____ Group #: _____
Service Code #: _____
Social Security number of Policyholder: _____
Employer Name: _____
Name of policyholder: _____
Birth Date of policyholder: _____
Address of policyholder: _____
City: _____ State: ____ Zip: _____ Phone: _____

Secondary Insurance Information:
Insurance Company name: _____
Policy Number or Contract # _____ Group #: _____
Service Code #: _____
Social Security number of this policyholder: _____
Employer Name: _____
Name of secondary policyholder: _____
Birth Date of second responsible party: _____
Address of second policyholder: _____
City: _____ State: ____ Zip: _____ Phone: _____

I understand as the primary responsible party, I will pay for all portions of charges that my insurance Company does not cover. I authorize the Center for Integrative Psychology to electronically transmit the claim to the insurance company, send any necessary documentation and discuss this case including diagnosis and other information from the clinical record with the insurance companies listed. I authorize my insurance company to send benefits directly to the Center for Integrative Psychology.

In the case of canceled appointments, I agree to provide **48 hours** notice to the Center for Integrative Psychology or be responsible for a $150 missed appointment fee that is not covered by the insurance company.

Signature of Responsible Party: _____ Date: _____

This is an adaptation from an intake form developed by Daniel Amen, M.D.