

Child Intake Form

Quality Life Group Psychiatric and Psychological Services

Parent Information

Name: _____, Sex: _____, Age: _____

Ethnicity _____, Race _____

Date of Birth: _____, Email address: _____

Address: _____, City: _____

State: _____, County, _____, Zip: _____

Telephone numbers:

Home: () _____, Work: () _____

Cell: () _____

Referral by: _____

Person to notify in case of emergency: _____

Emergency Contact Telephone Number: () _____

School/ Employer: _____

Marital Status: _____

Insurance Company Information

Name of Insurer: _____

Member Number: _____

Authorization Number: _____

Insurer's Telephone Number: () _____; () _____

Insurer's email: _____

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Child's Information

Name: _____, Age: _____, Date of Birth: _____,

Ethnicity: _____, Race: _____,

Address: _____, City: _____

State: _____, County, _____, Zip: _____ Email _____

Telephone numbers:

Home: () _____, Work: () _____

Cell: () _____

Referral by: _____

Person to notify in case of emergency: _____

Emergency Contact Telephone Number: () _____

Marital Status: _____

Name of School/

Employer: _____

Coordination of Care:

Primary Care Doctor _____; Phone number _____

Email _____; Telephone number _____

Street _____; City _____; State _____

Zip _____

Therapist/Psychologist _____; Phone number _____

Email _____; Telephone number _____

Street _____; City _____; State _____

Zip _____

I agree to release my child's diagnosis and treatment recommendation information to my insurance company for billing and coordination of care:

yes ___ no ___

I agree to release my child's diagnosis and treatment recommendation information to my primary care provider for coordination of care:

yes ___ no ___

I agree to release my child's diagnosis and treatment recommendation information to my therapist/psychologist for coordination of care:

yes ____, no ___

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Mental Health information:

Please describe the main reason you are seeking mental health care for your child:

Age first sought psychiatric/ psychological care and reason:

Medical History

Did your child have any exposure to the following substances during the pregnancy?

Intrauterine Factors	Trimester	Suspected / Confirmed Causality
Planned Pregnancy		
Cocaine exposure		
Amphetamine exposure		
Marijuana exposure		
Alcohol exposure		
Tobacco exposure		
Opiate exposure		

Were there any problems during few weeks immediately follow birth

Para-natal	Severity
Phototherapy	1 2 3 4 5
Transfusion	1 2 3 4 5
NICU	1 2 3 4 5
Feeding	1 2 3 4 5

Child Intake Form

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Developmental factors

Developmental Milestones	Age Reached Milestone	In your opinion was this late, on time or early
Slept through the night		
Lifted head		
Crawled		
Used gestures to talk		
Talked using baby jargon		
Talked with two real words		
Talked with phrases		
Walked		
Accepted/showed affection		
Toilet trained		

Please indicate if you suffer from any of the following conditions, circle current, past or both and circle a number, 1 through 5 to indicate severity. 1 is mild, 3 is moderate, 5 is severity.

Infectious diseases	Current / Past	1 2 3 4 5
Allergies	Current / Past	1 2 3 4 5
Asthma/lung disease	Current / Past	1 2 3 4 5
Diabetes	Current / Past	1 2 3 4 5
Thyroid disease	Current / Past	1 2 3 4 5
Myocardial infarction	Current / Past	1 2 3 4 5
Hypertension	Current / Past	1 2 3 4 5
Liver disease	Current / Past	1 2 3 4 5
Cancer	Current / Past	1 2 3 4 5
Stroke	Current / Past	1 2 3 4 5
Head injury	Current / Past	1 2 3 4 5
Seizures	Current / Past	1 2 3 4 5
Suffocation/ drowning	Current / Past	1 2 3 4 5
Loss of consciousness	Current / Past	1 2 3 4 5
Headaches	Current / Past	1 2 3 4 5
Memory loss	Current / Past	1 2 3 4 5
Neurological disorder	Current / Past	1 2 3 4 5
Easy Bleeding/bruising	Current / Past	1 2 3 4 5
Sexual dysfunction	Current / Past	1 2 3 4 5
Pregnancy	Current / Past	1 2 3 4 5
Menopause	Current / Past	1 2 3 4 5
Kidney disease	Current / Past	1 2 3 4 5
Chronic pain	Current / Past	1 2 3 4 5
Excessive menstrual bleeding / pain	Current / Past	1 2 3 4 5
Gynecological condition/procedure	Current / Past	1 2 3 4 5
Skin Condition	Current / Past	1 2 3 4 5
Surgical Procedures	Current / Past	1 2 3 4 5

Child Intake Form

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Medication Allergies:

Please list all medications you are currently taking for medical illness:

Family Psychiatric History

Please indicate the blood relationship of your family members with a psychiatric condition as follows:

1st degree relative – biological child or parent; 2nd degree- biological grandparent, cousin, uncle, aunt, niece, nephew

Psychiatric care	Maternal / Paternal	1 st degree/ 2 nd degree
Anxiety disorder	Maternal / Paternal	1 st degree/ 2 nd degree
Depressive disorder	Maternal / Paternal	1 st degree/ 2 nd degree
Manic depression or Bipolar disorder	Maternal / Paternal	1 st degree/ 2 nd degree
Schizophrenia	Maternal / Paternal	1 st degree/ 2 nd degree
Psychotic disorder	Maternal / Paternal	1 st degree/ 2 nd degree
Attention deficit/ hyperactivity disorder	Maternal / Paternal	1 st degree/ 2 nd degree
Learning disorders	Maternal / Paternal	1 st degree/ 2 nd degree
Mental retardation	Maternal / Paternal	1 st degree/ 2 nd degree
Autistic disorder	Maternal / Paternal	1 st degree/ 2 nd degree
Substance abuse	Maternal / Paternal	1 st degree/ 2 nd degree
Psychiatric hospitalization	Maternal / Paternal	1 st degree/ 2 nd degree
Eating Disorder	Maternal / Paternal	1 st degree/ 2 nd degree
Narcolepsy	Maternal / Paternal	1 st degree/ 2 nd degree
Sleep disturbance	Maternal / Paternal	1 st degree/ 2 nd degree
Homicide attempt	Maternal / Paternal	1 st degree/ 2 nd degree
Suicide attempt	Maternal / Paternal	1 st degree/ 2 nd degree

Social History of Client:

Highest degree of education obtained:

Legal problems/ circumstances:

Main source of stress:

Negative experiences – physical or sexual abuse, domestic violence, trauma, loss:

Personal strengths/ weaknesses:

Personal goals/aspirations/ hopes/ dreams:

Spiritual/religious orientation/cultural issues

Child Intake Form

Quality Life Group Psychiatric and Psychological Services

Social History Considerations for Children

Social	When	Severity
divorce	Current / Past	1 2 3 4 5
different discipline styles among care givers	Current / Past	1 2 3 4 5
use of other drugs	Current / Past	1 2 3 4 5
separation	Current / Past	1 2 3 4 5
poor school performance	Current / Past	1 2 3 4 5
pregnancies	Current / Past	1 2 3 4 5
high degree of family conflict	Current / Past	1 2 3 4 5
poor school attendance	Current / Past	1 2 3 4 5
incarceration	Current / Past	1 2 3 4 5
conflict between caregivers	Current / Past	1 2 3 4 5
Suspensions	Current / Past	1 2 3 4 5
probation	Current / Past	1 2 3 4 5
domestic violence	Current / Past	1 2 3 4 5
Detentions	Current / Past	1 2 3 4 5
few friends	Current / Past	1 2 3 4 5
witness of domestic violence	Current / Past	1 2 3 4 5
use of alcohol	Current / Past	1 2 3 4 5
dangerous friends	Current / Past	1 2 3 4 5
sibling fights	Current / Past	1 2 3 4 5
use of marijuana	Current / Past	1 2 3 4 5
actual or desired gang membership	Current / Past	1 2 3 4 5
multiple care givers	Current / Past	1 2 3 4 5
use of amphetamines	Current / Past	1 2 3 4 5
traumatic experiences	Current / Past	1 2 3 4 5

Psychiatric History of Client

Please indicate any psychiatric/ psychological care you have received, your approximate age at that time and your satisfaction with the treatment:

Child Intake Form

Quality Life Group Psychiatric and Psychological Services

List all psychiatric medications prescribed; the reason prescribed; the duration; and effect by completing the following table.

Name of medication	Reason prescribed	Date started	Date ended/ reason for stopping	Helpful? Yes/No Side effects?

Child Intake Form

Quality Life Group Psychiatric and Psychological Services

Psychiatric History Continued:

Please indicate if the following is current, past or both.

Please indicate the frequency using the following scale:

Almost Never (1); Sometimes (3); Almost Always (5)

Depression Symptoms	When	Frequency
Depressed mood	Current / Past	1 2 3 4 5
Loss of pleasure	Current / Past	1 2 3 4 5
Loneliness	Current / Past	1 2 3 4 5
Decreased appetite	Current / Past	1 2 3 4 5
Increased appetite	Current / Past	1 2 3 4 5
Poor concentration	Current / Past	1 2 3 4 5
Crying spells	Current / Past	1 2 3 4 5
Suicide thoughts	Current / Past	1 2 3 4 5
Homicide thoughts	Current / Past	1 2 3 4 5
Isolation	Current / Past	1 2 3 4 5
Irritability	Current / Past	1 2 3 4 5
Weight loss	Current / Past	1 2 3 4 5
Weight gain	Current / Past	1 2 3 4 5
Anger	Current / Past	1 2 3 4 5

Mania Symptoms	When	Frequency
Increased energy	Current / Past	1 2 3 4 5
Racing thoughts	Current / Past	1 2 3 4 5
Rapid speech	Current / Past	1 2 3 4 5
Less than four hours sleep per night	Current / Past	1 2 3 4 5
Euphoria	Current / Past	1 2 3 4 5
Invincibility	Current / Past	1 2 3 4 5
Irritability	Current / Past	1 2 3 4 5
Anger	Current / Past	1 2 3 4 5
Violent outburst	Current / Past	1 2 3 4 5
Sexual impulsivity	Current / Past	1 2 3 4 5
Financial impulsivity	Current / Past	1 2 3 4 5
Mood swings	Current / Past	1 2 3 4 5

Child Intake Form

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Anxiety Symptoms	When	Frequency
Excessive worrying	Current / Past	1 2 3 4 5
Muscle stiffness	Current / Past	1 2 3 4 5
Panic attacks	Current / Past	1 2 3 4 5
Avoiding things	Current / Past	1 2 3 4 5
Unwanted fears	Current / Past	1 2 3 4 5
Unwanted rituals	Current / Past	1 2 3 4 5
Unwanted habits	Current / Past	1 2 3 4 5
Procrastination	Current / Past	1 2 3 4 5

Psychosis Symptoms	When	Frequency
Hearing voices	Current / Past	1 2 3 4 5
Seeing things	Current / Past	1 2 3 4 5
Paranoia	Current / Past	1 2 3 4 5
Special powers	Current / Past	1 2 3 4 5
TV, Radio, News talks to you or about you personally	Current / Past	1 2 3 4 5

Behavioral Symptoms	When	Frequency
Disobedient at school	Current / Past	1 2 3 4 5
Disobedient at home	Current / Past	1 2 3 4 5
Tantrums lasting more than 5 minutes	Current / Past	1 2 3 4 5

ADHD Symptoms	When	Frequency
Overly active	Current / Past	1 2 3 4 5
Constantly in motion	Current / Past	1 2 3 4 5
Constantly talking	Current / Past	1 2 3 4 5
Constantly interrupting	Current / Past	1 2 3 4 5
Annoying to peers	Current / Past	1 2 3 4 5
Annoying to adults	Current / Past	1 2 3 4 5
Constantly distracted	Current / Past	1 2 3 4 5
Forgetful	Current / Past	1 2 3 4 5
Inattentive	Current / Past	1 2 3 4 5