

Intake-Peds age 6-12

How did you hear about our practice? *

Referral From
Another Provider

Referral From
Friend/Family

Google

Social Media

Advertisement

Parent or Guardians Name: *

Parent or Guardians Relationship to
Patient: *

Parent or Guardians E-mail: *

Form Completed By: Name/Relationship to
patient: *

Primary Language: *

Hispanic or Latino? *

Yes No

Race/Ethnicity: *

Emergency Contact:

Name: *

Relationship: *

Phone Number: *

Allergies

Allergies	Type	Severity	Reactions

Please provide name of medication and dosage amount

List each medication your child takes on its own line.

Medications

Medication Name	Intake Details

Supplements

Supplement Name	Intake Details

Has your child ever seen a Psychiatrist before? * Yes No

If so please provide the name and address:

Has your child ever or are they now seeing a therapist or counselor? * Yes No

If so please provide the name and address:

Primary Care Provider

Practice Name: *

Practice Address: *

Practice Phone Number: *

Pharmacy:

Name: *

Address: *

Phone Number: *

Describe in detail the reason for bringing your child in for this appointment:

Chief Complaints

Please review the following list of medical conditions. For each category, check all that apply. If none apply, please select 'no history.' If you choose 'other,' please specify in the provided space.

Past Medical History

Head concussions trauma TBI other no history

Comments _____

Eyes Blindness Cataracts Glaucoma
 Wears Glasses/Contacts Other No History

Comments _____

Ears Cochlear Implant
 Hearing Loss
 Right Ear (R/AD)
 Left Ear (L/AS)
 Both Ears (B/AU)
 Hearing Aids
 Other
 No History

Comments _____

Nose/Sinuses Allergic Rhinitis Sinus Infections Other
 No History

Comments _____

Mouth/Throat/Teeth

- Dentures Missing Teeth Wisdom Teeth Removal
 Spacers Dental Caries (Cavities)
 Refusal to Brush Teeth Other No History

Comments _____

Cardiovascular

- Aneurysm Angina Deep Vein Thrombosis (DVT)
 Dysrhythmia (Irregular Heartbeat) Hypertension (HTN)
 Heart Murmur Myocardial Infarction (Heart Attack)
 Other No History

Comments _____

Respiratory

- Asthma Bronchitis
 Chronic Obstructive Pulmonary Disease (COPD) Pleuritis
 Pneumonia Other No History

Comments _____

Gastrointestinal

- Cirrhosis Irritable Bowel Syndrome (IBS)
 Crohn's Disease Gastroesophageal Reflux Disease (GERD)
 Gallbladder Disease Heartburn Hemorrhoids
 Hepatitis Hiatal Hernia Jaundice Ulcer
 Other No History

Comments _____

Genitourinary

- Hernia Incontinence Kidney Stones (Nephrolithiasis)
 Other Kidney Disease Sexually Transmitted Diseases (STDs)
 Urinary Tract Infections (UTIs) Other No History

Comments _____

Musculoskeletal

- Arthritis Amputation Gout
 Musculoskeletal Injury (M/S Injury) Osteoporosis
 Scoliosis Other No History

Comments _____

Skin

- Acne Dermatitis Moles Psoriasis
 Chronic Wounds Other No History

Comments _____

Neurological

- Intellectual Disability Epilepsy Seizures
 Severe Headaches/Migraines Stroke
 Transient Ischemic Attack (TIA) Other No History

Comments _____

Endocrine

- Goiter Hyperlipidemia (High Cholesterol)

 Hypothyroidism Hyperthyroidism
 Hypoglycemia (Low Blood Sugar) Thyroid Disease
 Thyroiditis Type I Diabetes Mellitus (DM)
 Type II Diabetes Mellitus (DM) Other No History

Comments _____

Hematology/Oncology

- History of Blood Transfusions Anemia Cancer
 Other No History

Comments _____

Infections

- Human Immunodeficiency Virus (HIV) Tuberculosis (Disease)
 Tuberculosis (Exposure) Other No History

Comments _____

Sleep quality and amount:

- early waking difficulty sleeping difficulty staying awake
 nightmares night terrors bad good
 wake frequently through out night wake rested
 does not wake up rested 1-3 hours 4-6 hours
 8 hours 10+ hours

Comments _____

Weight and appetite:

- little to no appetite decreased appetite
 average/balanced appetite increased appetite
 underweight average weight over weight
 picky eater weight gain weight loss

Comments _____

Prior Hospitalizations/Surgeries (if yes please list):

- Yes No

Past Psychiatric History

Previous Psychiatric Diagnosis:

- none ADHD adjustment disorders anxiety
 bipolar-disorder catatonic/tic disorder
 depressive disorder dissociative disorder
 eating disorder GAD/separation anxiety disorder
 impulse-control disorder neurocognitive disorder
- O.C.D. and related disorders P.T.S.D.
 panic disorder/phobias personality disorders
 sleep-wake disorders

Comments _____

Prior Outpatient MH care:

- Yes No

Comments _____

Suicide attempts:

- Yes No

Comments _____

Inpatient MH Care/Psych Hospitalization:

- Yes No

Comments _____

Non-Suicidal Self-Directed Violence:

- Yes No

Comments _____

Psychotropic medication trials

Dates taken	Medication	Dose	Why stopped

Has the patient experienced any behavioral addictions? If so, please select from the following:

- Denies
 Compulsive gambling
 Internet / social media
 Video gaming
 Sex / pornography
 Shopping
 Hoarding
 Binging
 Purging

Comments _____

Family History

Household members:

- mother
 father
 step-mother
 step-father
 siblings
 brother(s)
 sister(s)
 grandparent(s)
 other

Comments _____

Adopted or in Foster care?

- no
- adopted
 - with sibling(s)
 - separated from sibling(s)
- prior foster care
 - with sibling(s)
 - separated from sibling(s)
- relative/kinship
 - informal kinship care that did not involve the child welfare system
 - with sibling(s)
 - separated from sibling(s)
 - voluntary kinship care. The child welfare system is involved.
 However, the State did not take legal custody.
 - with sibling(s)
 - separated from sibling(s)
 - Formal kinship care: A judge placed the child/children in the legal custody of the State and a child welfare system placed the children with relatives.
 - with sibling(s)
 - separated from sibling(s)
- Non-related kinship care (NRKIN). The child was placed with someone whom they are familiar with but who is not related.
 - with sibling(s)
 - separated from sibling(s)
- Traditional foster care
 - with sibling(s)
 - separated from sibling(s)
- Specialized, therapeutic, or medical foster care
 - with sibling(s)
 - separated from sibling(s)
- Emergency foster care
 - with sibling(s)
 - separated from sibling(s)

Comments _____

Parents divorced?

- no yes never married separated N/A

Comments _____

Mother alive? If yes, her age and occupation? If no, cause of death?

- Yes No N/A

Comments _____

Relationship with mother:

- abusive avoidant chaotic controlling
 loving no contact reliable supportive
 stable other N/A

Comments _____

Father alive? If yes, his age and occupation? If no, cause of death?

- Yes No N/A

Comments _____

Relationship with father:

- abusive avoidant chaotic controlling
 loving no contact reliable supportive
 stable other N/A

Comments _____

Siblings:

- No siblings One sibling Multiple siblings
 Sibling(s) deceased Half-sibling(s) Step-sibling(s)
 Adopted sibling(s)
 Other _____

Comments _____

Do all siblings live in the same household?

- yes no sometimes no siblings

Comments _____

Relationship with siblings:

- close functional loving reliable stable
 supportive abusive chaotic distant
 unhealthy no contact N/A

Comments _____

Current Social/Familial Support:

- Significant – My child has strong and consistent support from family, friends, or community.
- Occasional – My child has support, but it's infrequent or not always reliable.
- Minimal – My child has very little support from family, friends, or community.
- None – My child does not have any social or familial support at this time.
- Uncertain – I am unsure about the reliability or consistency of my child's support system.

Comments _____

Family Psych Hx:

- ADHD Anxiety Bipolar Depression
- Dementia Schizophrenia Substance abuse
- Other N/A

Comments _____

Exposure to substance abuse in home/prior home:

- yes
 - cigarettes
 - alcohol
 - opioids
 - cannabis
 - other
- no

Comments _____

Social History

Current Living Situation:

Patient Reports feeling:

- safe
 - at home
 - at school
 - at friends home(s)
 - overall
 - other
- unsafe
 - at home
 - at school
 - at friends home(s)
 - overall
 - other

Comments _____

Is your child Homeschooled?

- Yes No

Current school:

Current grade level:

Academic performance:

- above average average struggling
 held back recently

Comments _____

IEP/504 plan or additional educational support:

- Yes No

Comments _____

In special education?

- Yes No

Comments _____

History of abuse

- Denies Sexual Physical Verbal
 Other _____

Comments _____

Sexual Orientation

- Heterosexual Homosexual Bisexual Other

Comments _____

Gender Identity:

- Male Female Gender Neutral/Fluid
 Other _____

Comments _____

Spiritual Status:

- Agnostic
 Atheist
 Christianity
 Catholic
 Eastern Orthodox
 Fundamentalist
 Protestant
 Other
 Islam
 Sunni
 Shi'a
 Judaism
 Orthodox
 None

Comments _____

History of arrests:

- Yes No

Comments _____

History of violence

- Yes No

Comments _____

Significant Life Events:

- None
- Recent loss of a loved one (e.g., death, separation, divorce)
 - parent
 - sibling
 - other
- Major relationship changes in family (e.g., divorce, separation, reconciliation)
- Family Financial difficulties or significant changes in income
- Serious illness, injury, or medical diagnosis (self or loved one)
 - self
 - loved on
- Recent relocation or major move
- Legal issues (e.g., lawsuits, custody battles, criminal charges)
- Traumatic events (e.g., accidents, assaults, natural disasters)
- Other _____

Comments _____

Social Function and Peer Relationships:

- few friends, but not close a few close friends
- many friends states no friends bullied
- no fear of going out fearful of going out likes school
- dislikes school

Comments _____

Extracurriculars:

- none sports at school sports outside of school
- clubs/organizations at school
- clubs/organizations outside of school other

Comments _____

Has a cell phone:

- Yes No

Present on social media:

- Yes No

Comments _____

Birth and Development

Birth:

full-term pre-term

Comments _____

Pregnancy complications?

Yes No

Comments _____

Perinatal complications?

Yes No

Comments _____

Maternal substance abuse during pregnancy?

yes
 cigarettes
 alcohol

 opioids
 cannabis
 other
 no

Comments _____

Illness during infancy?

Age when first walked:

Age when first talked in phrases/short sentences:

Age when toilet training was completed:

Any enuresis/encopresis (bedwetting or soiling) currently?

Yes No

Comments _____

Developmental milestones met?

Yes No

Comments _____