Alder Grove Health Services, Inc.

**Psychiatric Intake Form – Child and Adolescent**
***(All information on this form is strictly confidential)***

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. Thank you!

Client Name_______________________________________________Date_____________

Date of Birth __________ Primary Care Provider______________________________

Current Therapist/Counselor______________ Therapist's Phone________________

Preferred Pharmacy: ____________________________________________
What are the problem(s) you are seeking help for?
1.____________________________________________________________
2.____________________________________________________________
3.____________________________________________________________

What are your treatment goals?
______________________________________________________________
______________________________________________________________
______________________________________________________________

**List ALL current prescription medications and how often your child takes them**: (if none, write none)

| Medication Name | Total Daily Dosage | Estimated Start Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Current over-the-counter medications or supplements
______________________________________________________________

Current medical problems:_______________________________________

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Allergies to medication or food: _________________________________

Past medical problems, non-psychiatric hospitalization or surgeries ________

________________________________________________________________________________

Have your child ever had an EKG? ( ) Yes ( ) No If yes, when ________. Was the EKG normal ( ) abnormal ( ) or unknown ( )?

Date and place of last physical exam:________________________________________________

**Personal Medical History:**
**Has your child had any of the following?**

| | Yes | No | Comment |
|---|---|---|---|
| Allergies------------------------------ | ( ) | ( ) | ____________________ |
| Allergies to medications------------- | ( ) | ( ) | ____________________ |
| Asthma-------------------------------- | ( ) | ( ) | ____________________ |
| Hearing Problems-------------------- | ( ) | ( ) | ____________________ |
| Vision Problems --------------------- | ( ) | ( ) | ____________________ |
| Diabetes ------------------------------- | ( ) | ( ) | ____________________ |
| Meningitis/Encephalitis----------- | ( ) | ( ) | ____________________ |
| Head Injury------------------------- | ( ) | ( ) | ____________________ |
| Concussion ------------------------- | ( ) | ( ) | ____________________ |
| Seizures (convulsions) ------------- | ( ) | ( ) | ____________________ |
| Heart Problems ---------------------- | ( ) | ( ) | ____________________ |
| Dizzy/passed out with exercise---- | ( ) | ( ) | ____________________ |
| Irregular/Abnormal rapid heart beat | ( ) | ( ) | ____________________ |
| Other injuries -------------------- | ( ) | ( ) | ____________________ |
| High blood pressure----------------- | ( ) | ( ) | ____________________ |
| *Stomach/GI problems* -------------- | ( ) | ( ) | ____________________ |
| Other illnesses ---------------------- | ( ) | ( ) | ____________________ |
| Any medical hospitalization------- | ( ) | ( ) | ____________________ |
| Autoimmune disease -------------- | ( ) | ( ) | ____________________ |

**Family Medical History:**
**Please check illness that any of your child's biological relatives have experienced.**

| | Yes | *Which family member* |
|---|---|---|
| Allergies------------------------------ | ( ) | ____________________ |
| Sudden death before age 50 yrs--- | ( ) | ____________________ |
| Asthma-------------------------------- | ( ) | ____________________ |
| Epilepsy/Seizures------------------- | ( ) | ____________________ |
| Learning problems ----------------- | ( ) | ____________________ |

Diabetes ------------------------------- ( ) ________________________________
*Heart problems*---------------------- ( ) ________________________________
High blood pressure------------------ ( ) ________________________________
High cholesterol-------------------- ( ) ________________________________
Legal problems----------------------- ( ) ________________________________
Tics------------------------------------ ( ) ________________________________
Autism Spectrum disorder --------- ( ) ________________________________
Eating disorder ---------------------- ( ) ________________________________
Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain

______________________________________________________________________

______________________________________________________________________

**Birth Information:**
Were there any complications during the pregnancy or birth?

______________________________________________________________________

Was the delivery: On time______ Early (how many weeks?) _____________
Did the biological mother smoke during pregnancy? _________ drink alcohol?_______
Use illicit drugs? ___________

**Past Psychiatric History**
***Outpatient treatment***( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

| Reason | Dates treated | By whom |
|---|---|---|
| | | |
| | | |
| | | |

***Psychiatric Hospitalization*** ( ) Yes ( ) No If yes, describe for what reason, when and where.

| Reason | Date Hospitalized | Where |
|---|---|---|
| | | |
| | | |
| | | |

***Psychiatric Medications:***
Please list any previous psychiatric medications your child has been prescribed and why the med was discontinued:

| Medication | Dosage | Reason Discontinued |
|---|---|---|
| | | |
| | | |
| | | |

**Family Psychiatric History**:
Has anyone in your biological family been diagnosed with or treated for:

| | | | |
|---|---|---|---|
| Bipolar disorder | ( ) Yes ( ) No | Schizophrenia | ( ) Yes ( ) No |
| Depression | ( ) Yes ( ) No | Post-traumatic stress | ( ) Yes ( ) No |

| | | | |
|---|---|---|---|
| Anxiety | ( ) Yes ( ) No | Alcohol abuse | ( ) Yes ( ) No |
| *Anger* | *( ) Yes ( ) No* | *Other substance abuse* | ( ) Yes ( ) No |
| Suicide | ( ) Yes ( ) No | Violence | ( ) Yes ( ) No |
| ADHD | ( ) Yes ( ) No | | |

If yes, who had what problems?______________________________________________

______________________________________________

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No
If yes, who was treated and what medications and how effective was the treatment?______________________________________________

***Substance Use:***
Has your child ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? ______________________________________________
If yes, where were you treated and when? ______________________________________________

______________________________________________

**Family Background and Childhood History**:
Is your child adopted? ( ) Yes ( ) No , if so at what age was he/she adopted? ________
Please list names of everyone who lives with your child:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Are the parents/caregivers of this child married ( ), divorced ( ), never married ( ), separated (
If parents are divorced, with whom does the child live?______________________________

**Trauma History**:
Does your child have a history of being abused emotionally, sexually, physically or by *neglect? ( ) Yes ( ) No.*
Please describe when, where and by whom ______________________________________________

______________________________________________

**Educational Information**:
Name of current school: ______________________________ Grade: ______________
Grades repeated ____________ Grades skipped ____________ Expelled? Yes ( ) No ( )
Does your child have any known learning differences? ______________________________
Does your child have an IEP? Yes ( ) No ( )
Is your child receiving any special education services (speech, reading, etc)
*Yes ( ) No ( ) Explain:*

______________________________________________

______________________________________________

How has your child's behavior and academic performance been over the past month? Explain:

______________________________________________

______________________________________________

**Legal**: Has your child ever been arrested? ______ Does she/he have any pending *legal problems?* ______________

**Spiritual life**
Does your child belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of her/his involvement? ___________________________

Alder Grove Health Services, Inc.

## DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

**Child's Name:** ______________________ **Age:** ____ **Sex:** ☐ Male ☐ Female **Date:** __________

**Relationship with the child:** ____________________________________________

**Instructions** *(to the parent or guardian of child)*: The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.

| | | During the past **TWO (2) WEEKS**, how much (or how often) has your child... | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
|---|---|---|---|---|---|---|---|---|
| I. | 1. | Complained of stomachaches, headaches, or other aches and pains? | 0 | 1 | 2 | 3 | 4 | |
| | 2. | Said he/she was worried about his/her health or about getting sick? | 0 | 1 | 2 | 3 | 4 | |
| II. | 3. | Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early? | 0 | 1 | 2 | 3 | 4 | |
| III. | 4. | Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game? | 0 | 1 | 2 | 3 | 4 | |
| IV. | 5. | Had less fun doing things than he/she used to? | 0 | 1 | 2 | 3 | 4 | |
| | 6. | Seemed sad or depressed for several hours? | 0 | 1 | 2 | 3 | 4 | |
| V. & | 7. | Seemed more irritated or easily annoyed than usual? | 0 | 1 | 2 | 3 | 4 | |
| VI. | 8. | Seemed angry or lost his/her temper? | 0 | 1 | 2 | 3 | 4 | |
| VII. | 9. | Started lots more projects than usual or did more risky things than usual? | 0 | 1 | 2 | 3 | 4 | |
| | 10. | Slept less than usual for him/her, but still had lots of energy? | 0 | 1 | 2 | 3 | 4 | |
| VIII. | 11. | Said he/she felt nervous, anxious, or scared? | 0 | 1 | 2 | 3 | 4 | |
| | 12. | Not been able to stop worrying? | 0 | 1 | 2 | 3 | 4 | |
| | 13. | Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous? | 0 | 1 | 2 | 3 | 4 | |
| IX. | 14. | Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her? | 0 | 1 | 2 | 3 | 4 | |
| | 15. | Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see? | 0 | 1 | 2 | 3 | 4 | |
| X. | 16. | Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else? | 0 | 1 | 2 | 3 | 4 | |
| | 17. | Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off? | 0 | 1 | 2 | 3 | 4 | |
| | 18. | Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned? | 0 | 1 | 2 | 3 | 4 | |
| | 19. | Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening? | 0 | 1 | 2 | 3 | 4 | |
| | | In the past **TWO (2) WEEKS**, has your child ... | | | | | | |
| XI. | 20. | Had an alcoholic beverage (beer, wine, liquor, etc.)? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| | 21. | Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| | 22. | Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| | 23. | Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| XII. | 24. | In the past **TWO (2) WEEKS**, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide? | ☐ Yes | | ☐ No | ☐ Don't Know | | |
| | 25. | Has he/she EVER tried to kill himself/herself? | ☐ Yes | | ☐ No | ☐ Don't Know | | |

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*Is there anything else that you would like your provider to know?*

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Signature___________________________________________Date_________________________

Reviewed by ________________________________________Date ________________________