Blue Umbrella Psychiatry
6100 Griffin Rd. 2nd Floor
Davie, FL - 33314-4416

** 2027 New Child/Adolescent Intake

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Marital Status ☐ Single ☐ Married ☐ Others

Language(s)

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black of African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Fax

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

Address Line2

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City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

Caregiver(s) First Name *

Caregiver(s) Last Name *

Allergies

Allergies	Type	Severity	Reactions

Medications

Medication Name	Intake Details

If your child has ever taken any medications, please indicate dosage. If helpful, include side effects and reasons for discontinuing medication *

Supplements

Supplement Name	Intake Details

Please list the name of your pharmacy with address below *

Emergency Contact Name

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Emergency Contact Number _____

SCHOOL AND EDUCATIONAL HISTORY

What school does your child attend? *

What grade is your child in? Have they ever been held back?

Does your child currently have an Individualized Education Program (IEP), Section 504 plan, or other educational accommodations?

☐ no ☐ yes ☐ in progress ☐ unsure

If yes, please describe the supports, accommodations, or services provided. If available, you may bring a copy of the current plan.

Are there any current academic, behavioral, attention, learning, or social difficulties at school? *

☐ Yes ☐ No

If yes, please describe the concerns and when they began.

Has your child ever been suspended or expelled?

☐ Yes ☐ No

Has your child received school-based counseling, behavioral support, tutoring, or other educational services? *

☐ Yes ☐ No

If yes, please describe the services and any relevant outcomes.

DEVELOPMENTAL HISTORY

Any complications during pregnancy or delivery? *

☐ Yes ☐ No

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Is your child adopted? If yes from where, what age?

Did your child meet all developmental milestones? If no, what delays were present? *

☐ Yes ☐ No ☐ Unsure

Has your child received early intervention, developmental therapy, speech therapy, occupational therapy, physical therapy, or other developmental services?

☐ Yes ☐ No

Does your child display significant aggression, irritability or violence towards themselves or others?

Who is your child's current therapist? Please provide name, address and phone number *

Who is your child's Primary Care provider. Please provide name, address and phone number *

Who is your child's current or prior psychiatrist?

What are the problem(s) for which you are seeking treatment?

What are your treatment goals?

Please list all medical problems (for example history of head trauma, seizures, chronic pain, heart, liver or kidney disease, neurologic illness, migraines.) Indicate which ones are currently active

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Family History of any psychiatric problems Include which family member

☐ Depression ☐ Anxiety Disorder ☐ Psychosis
☐ Bipolar Disorder ☐ Drug problems

Has your child been admitted to an inpatient psychiatric unit? When? Why?

Any history of physical, emotional or sexual abuse or neglect? Any history of bullying? *

Who lives with your child currently? Does your child live in one home or multiple homes?

What are your child's primary stressors currently?

Anything else you would like me to know?

PARENT/GUARDIAN ACKNOWLEDGMENT

I confirm that the information provided is accurate to the best of my knowledge. I understand that this questionnaire supplements the appointment request and does not replace the provider's clinical evaluation. I have reviewed my responses and confirm that the information provided is accurate to the best of my knowledge.

PARENT GUARDIAN SIGNATURE *

TODAY'S DATE *