Psychiatry Intake Form (Under Age 18)

Child's Full Name_____Child's Date of Birth_____

Who is completing this form and what is your relationship to the child?

_____

Who lives at home with the child, including adults and other children?

_____

Who are the child's legal guardians?

_____

Is the child adopted or in foster care? **Yes** **No**
Are there any firearms or other weapons in the home? **Yes** **No**

What are the problems or concerns for which you are seeking help?

1._____
2._____
3._____
4._____

What mental health conditions has your child previously been diagnosed with?

_____

Has your child ever stayed overnight in the hospital for mental health reasons? **Yes** **No**
Has your child ever been to the emergency room for mental health reasons? **Yes** **No**
Has your child ever attempted suicide or self-harmed? **Yes** **No**
Does your child have concerns about their sexual orientation or gender identity? **Yes** **No**

Has your child ever been in therapy or counseling for mental health concerns? **Yes** **No**
Current Therapist/Counselor (if applicable)_____
Current Therapist/Counselor Phone or Email _____

Has your child ever had testing completed by a psychologist or through their school, including IQ testing, achievement testing, or testing for autism spectrum disorder? **Yes** **No**
If so, where was the testing done? _____

Has anyone related to your child ever been treated for mental health conditions or substance abuse? Examples include depression, anxiety, OCD, ADHD/ADD, autism, learning disabilities, bipolar disorder, schizophrenia, suicide attempts, alcoholism, or drug use. **Yes** **No**
If yes, please explain:

_____

_____

List all **current** prescriptions, other medications, and supplements your child is taking:

Medication Name	Dose	Estimated Start Date

List any **past** medications that your child has tried for behavioral or mental health concerns:

Medication Name	Dose	Estimated Dates Taken

What school does your child attend? _____

Current Grade: _____ Has your child ever repeated a grade? **Yes** **No**

Does your child have an IEP, 504 plan, or any other extra help at school? **Yes** **No**

Who should we contact at your child's school if needed, including their phone or email?

_____

In the past, has your child ever:

- Been neglected **Yes** **No**
- Been physically abused **Yes** **No**
- Been emotionally or verbally abused **Yes** **No**
- Been sexually abused or assaulted **Yes** **No**
- Been bullied **Yes** **No**
- Witnessed domestic violence **Yes** **No**
- Experienced another traumatic event **Yes** **No**

Radiology Special Labs Letters Old Records
Hospital ER/UC Screens Reports (Forms/Orders)
Visit Date/Order _____ OR
Date of Document _____
Label Psych Intake
Result/Notes _____
_____
_____ Initials TM

To your knowledge, has your child ever used nicotine products (including vaping), alcohol, or illicit drugs (including marijuana)? **Yes** **No**

Has your child received physical therapy, occupational therapy, or speech therapy? **Yes** **No**

Were there any problems during the pregnancy or birth of your child? **Yes** **No**

Was your child exposed to any nicotine, alcohol, or drugs during the pregnancy? **Yes** **No**

I grant permission for Pediatric Associates of Mt. Carmel to obtain information from and maintain contact with any of the persons listed above about my child's mental health history, if it is felt to be necessary to provide optimal care for my child. **Yes** **No**

Guardian's Signature: _____

Printed Name: _____ Date: _____