CHaD Departments of Pediatric Development and Child Psychiatry

Child/Adolescent Intake Information

This questionnaire will help us provide you and your child with the best possible treatment.

Please fill out all of the questions as completely as possible.

Name of patient: ____ Date of Birth: ____________

Age: _____________

Person Completing the Questionnaire ____
Relationship to Child: ______________________

Legal Guardian(s)____ Relationship to Child: ___________
Legal Guardian(s)____ Relationship to Child: ___________

Legal Guardian(s) email address:____

Where did your child live when he/she was born? City: ________________ State: ________________

Please note if the Legal Guardian is not attending the appointment we must speak with them before scheduling. Please put contact number here: ____

What are the major concerns or questions you would like addressed in this evaluation?

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Are you connected to your local area agency? **Yes No**

If yes, what is the name of the Agency? ____
Name of Service Coordinator: ____
Service Coordinator Phone Number: _____________________________________

Do you have specific concerns about:

How your child will do at the visit? **Yes No**

Your child's language skills? **Yes No**

Your child's motor skills? **Yes No**

Your child's eating habits? **Yes No**

Use of drugs or alcohol or other non-prescription drugs? **Yes No**

Your child's sleep? **Yes No**

Your child's school performance? **Yes No**

If you marked "Yes" for any listed above please use the space on the next page to explain:

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Has your child had any other evaluations or assessments for these problems?
If so, please tell us who did it and when. (*Include school, any agencies, doctors, therapists, etc.*)

Please have copies of the assessments returned with this form, or sent to us

Name/Place of evaluator	When

Family

Please check if child is _____ adopted or _____ in foster care?
If you checked one of the following please indicate what age the child came to live in the current household ______

Parents (*if parents are separated, please circle which parent the child lives with most of the time*)

Parent #1
Name: _________________________________ Relation: __________ Occupation: ______________
Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Parent #2
Name: _________________________________ Relation: __________ Occupation: ______________
Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Please circle your preferred contact number(s) above

May we leave a message at the above numbers for you? **Yes** **No**

Emergency Contact:

Name: ____ Phone Number: ___________

Who is in the current household? (*Who lives with the child*)

Name	Age	Relationship	Contact Info

Other immediate family members (*Not living at home*)

Name	Age	Relationship	Contact Info

If parents are separated, does the non-custodial parent want to be involved in the treatment of the child?

Yes **No**

If yes, will both parents be able to attend the evaluation?

Yes **No**

Child's Schooling

Please list any daycare or schools that your child has attended:

Current School: ____

Prior School(s): ____

Child's Treatment History

Please list any diagnoses that your child has received for behavioral, developmental or mental health problems below. This could include things like Learning Problems; Attention Deficit Disorder; Anxiety; Depression; Sensory Processing Dysfunction; Tics; Autism Spectrum Disorder:

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Please list any medications your child is currently taking for behavioral or emotional problems.

Medicine	**How Taken?**	**Doctor**	**Since When?**	**Does it help**
Ex: Ritalin	5 mg in the morning and 5 mg after school.	PCP	Started 2 years ago	**Yes No**
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

List any other medications your child has taken in the past for any mental health or behavior problems

Medicine	**How Taken?**	**Doctor**	**Since When?**	**Does it help**
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Please bring all labeled medicine to your appointment

Please check all of the services your child has received:

Service	Receiving Now	Received In Past	Name/Location
Early Intervention			
School 504**			
School IEP **			
School behavior plan			
Home based services			
School based case management***			
DCYF involvement			
Individual therapy			
Family therapy			
Speech therapy			
Physical therapy			
Occupational therapy			
Genetic screening			
Developmental eval/services			
Neurology eval/treatment			
Mental health or Social Services Case Management ***			
Other:			

** Please enclose a copy of all assessments and current plans
*** Case Managers and Service Managers are encouraged to attend the appointment with you. Please invite them.

Child's Medical History

How long was your pregnancy with your child? _____ Full Term (*Born within two weeks of date due*)

_____ Born Premature at ___ weeks

_____ Unknown

Were there any complications during your pregnancy? **Yes** **No**
If yes, please explain:
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What was your child's weight at birth? ___________________

APGAR scores _____/_____ ___ Unknown

Did you have any problems at birth? **Yes** **No** **Unknown**
If yes, please explain:
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Early Development

As an infant or toddler did your child have trouble attaching or binding to either parent? **Yes** **No**
If yes, please explain:
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Were developmental milestones all on time? (*sitting up, walking, talkling, etc.*) **Yes** **No** **Unknown**
If no, please explain:
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Has your child ever had any of the following health problems?	**Yes**	**No**	**Unknown**	**When/Comments**
Seizure or convulsions				
Head injury with loss of consciousness				
Serious infection(s)				
Asthma				
Heart Murmurs				
Other Heart problems				
Serious Injury				
Surgery				
Problems with growth				

Add any details here:

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____

Please list any serious illness, operations, or hospitalizations not listed above:

Child's Age When Ill	Type of Illness/Injury	Treatment

Please list any medications your child is currently taking for medical and health purposes:

Medicine	When Started	Doctor	For What Condition

Family History

Please check any of the following that is known or suspected in biological relations:

Illness	Siblings	Biological Mother	Biological Mother's Family	Biological Father	Biological Father's Family
Mental Illness					
Substance Abuse (Drugs or alcohol)					
Learning Disabilities					
Anxiety Problems					
Epilepsy or other neurologic problems					
Heart Disease					
Genetic Disorder					
Attention Problems					
Autism Spectrum Disorder					
Other Developmental Disorder					
Mood Disorder (Depression, Bipolar)					
Other					

Provide additional info for anything checked, including what the diagnosis is and any other info that might be important:

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Any additional comments or information not addressed in this questionnaire:

Do you have any concerns on how this visit itself will go? Please explain:

Child's Pediatrician: ______________________________

Physician's Telephone number: (   )

Physician's Fax Number: (   )

Address: ______________________________

Please mail copies of the most recent reports, ISFP, any applicable/related information.