2448 S. 102nd Street
Suite 270
West Allis, WI 53227
Phone: (414) 444-9811

Date Form Completed:

Child/Adolescent Intake Form

If you need additional space for your responses, please include further details on the last page of this intake form.

Name of Patient: Date of Birth:

Referred by:

Person completing form if not patient:

Relationship to patient:

Gender: Ethnicity:

Household Income Level (please select one):

Below $22,000 $22-44,000 $44-78,000 Above $78,000

Describe what issue or concern led to this appointment:

When did you first notice this problem?

Have you (the patient) seen a counselor, psychologist, psychiatrist, or other mental health professional before (include any psychological testing completed as well)?

Yes No

If yes:

Name of therapist:	
Dates of Treatment :	
Reason for seeking help:	

Name of therapist:	
Dates of Treatment :	
Reason for seeking help:	

Describe any other treatment you (the patient) have tried for this or any other psychological/psychiatric issue in the past: (When, where, why, was/is it helpful)

	When	Where	Why	Was it helpful
Medication (mental health)				
Psychiatric hospitalization				
AODA Treatment program				
Self-help/support groups				

What do you hope to gain from this evaluation or the services you are receiving?

Developmental History

Pregnancy/Neonatal/Infancy:

Were there complications with the pregnancy of the patient's delivery (for instance prematurity, fetal distress, low Apgars, C-section)?

Were there any medical problems in the first two years of life?

Developmental milestones:

Are there now or have there ever been feeding/eating concerns?

Are/were there physical growth problems?

Did/does the patient experience colic?

Please describe the patients current sleep habits:

- Sleeping through the night?
- Sleeping alone?
- Difficulties with sleep (for example, waking early, restless sleep, difficulty falling asleep)? Yes No If yes, please describe:

Please provide the approximate age each of the following milestones were met:

- Age of walking

  Please described any current or past issues related to movement:

- Age of first words:
- Age of first sentences:

  Please described any current or past issues related to speech/language:

- Age of toilet training?

  Please described any current or past issues related to toilet training:

Describe any concerns related to eating/dieting or weight changes (drastic gain/loss, restrictive food behaviors, excessive eating or hoarding of food):

Describe any current or past hygiene concerns:

What are the patient's strengths?

What are the patient's weaknesses?

School History

Current grade and school attending (if not currently in school, please list school attended previous year and school will attend the following school year if different):

What other schools has the patient attended?

Has the patient received special education services? Please provide details of learning problems and any supports put in place.

*****If the patient currently has an IEP or 504 plan please provide a copy prior to testing. If you do not have a copy, please complete a release of information form so we may obtain a copy from the patient's school.*****

Are there concerns about the patient's current school program?

What is the patient’s attitude towards school?

What are the patient’s hopes for their educational and vocational future?

What are the parent’s or caregiver’s hopes for the patient’s educational and vocational future?

Social History

Please provide the names, ages, and occupations/grades of family members in the current household:

	Name	Relationship to patient	Age	Occupation/Grade
1				
2				
3				
4				
5				

Are there other family members or primary caretakers of the patient who reside outside of the primary home? (If yes, please provide their names and relationship to the patient)

Has the patient ever been the victim of abuse (emotional, sexual, or physical)?

Yes No

If yes, please indicate their age at the time of abuse, the type of abuse experienced:

Are there any particular stressors or recent changes in the family such as job changes, financial problems, changes in custody or placement, domestic problems, or abuse?

Who is responsible for discipline? What methods work or haven't worked?

How does the patient get along:

- with siblings?
- with peers?
- with parents?
- by themselves?

Describe any difficulty the patient has/had separating from their parents or caregivers:

Describe any concerns related to the patient making or maintaining friendships:

What are the patient's hobbies or favorite activities?

Please describe any regular family activities (ex. playing board games, weekend activities, watching movies, family meal times):

Medical History

Name of Physician:

Address:

Phone:

Date of Last Physical Examination:

Description of any concerns noted at last physical:

Has the patient seen a specialist, such as a neurologist, speech therapist, etc.? Please list names, approximate dates, and the reason for consultation.

Does the patient have any chronic medical conditions? Yes No

If yes, please list:

Do the patient have any CURRENT health concerns? Yes No

Please check and comment as necessary:

Asthma or breathing problems:

Headaches:

GI concerns:

Head injury history:

Seizures:

Ear Infections:

Frequent or recent strep infection:

Heart murmur or problems:

Hearing loss:

Vision problems:

Onset of puberty:

Risky sexual activity:

Major hospitalizations or surgeries:

Other:

Current prescription medications:

Medication	Dosage	Date First Prescribed	Prescribed by

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

Do you have allergies (environmental, food, and medication related) and/or adverse reactions to medications? Yes No

If yes, please list.

Family History

In the section below, identify if there is a family (biological) history of any of the following. If yes, please indicate the family member's relationship to the patient in the space provided (e.g. father, grandmother, uncle, etc.)

Family history of:		**Family member w/ history:**
Alcohol/Substance Abuse	Yes No	
Anxiety	Yes No	
Depression	Yes No	
Hyperactivity	Yes No	
Learning Disability	Yes No	
Eating Disorders	Yes No	
Seizures or Migraines	Yes No	
Cardiac (heart) issues	Yes No	
Obsessive Compulsive Behavior	Yes No	
Schizophrenia	Yes No	
Self-harm Behaviors	Yes No	
Suicide Attempts/ Death by suicide	Yes No	
Psychiatric hospitalization	Yes No	
Conduct Problems	Yes No	
Tics or Tourette's Disorder	Yes No	
Genetic syndromes (ie. Down's syndrome, cystic fibrosis, etc.)	Yes No	
Other:	Yes No	

Current Concerns/Symptoms

Please indicate which of the following behaviors or symptoms are of concern for the patient and provide brief detail on the nature of the behavior.

Concerns related to attention (Careless/poor attention to detail, difficulty sustaining attention, frequently loses things, is easily distracted, does not listen and/or follow through with requests, forgetful in daily activities, difficulty organizing):

Are these issues present in the home, in school, and/or in other settings?

Concerns related to activity level (fidgets, difficulty staying seated, often restless, difficulty playing quietly, always "on the go" or motor driven, excessive talking, interrupts or blurts out answers, difficulty waiting their turn):

Are these issues present in the home, in school, and/or in other settings?

Concerns related to behaviors (lying, stealing, running away, truancy, fire setting or fire play, cruelty to animals, inappropriate sexual behaviors/interests, threats of violence to family/peers/others, lack of conscience, exceptional negativity to rules):

Concerns related to substance use (alcohol, marijuana, cigarettes, and/or other substances):

Concerns related to emotional functioning:

Expresses feeling depressed, hopelessness, or low self-esteem:

Mood swings (circle or indicate period of chance/ duration of mood change: MINUTES, HOURS, DAYS, WEEKS, or MONTHS):

Mood change without reason:

Suicidal statements or actions:

Specific phobias or fears (going outside, heights, spiders, etc.):

Sudden feelings of panic:

Nail biting, skin picking, hair pulling, teeth grinding, etc:

Overly perfectionistic:

Obsessive thoughts or concerns (getting sick, germs, being late, changes to routine, etc.):

Sensory concerns (does not like specific fabrics, difficulty dealing with noise/light, etc.)

Head banging, rocking, arm flapping, spinning, or other repetitive behaviors:

Lack of affection (does not seek out or provide comfort):

Restricted or unusual conversational or play interests (only talks about specific topics, likes to line up/take apart toys instead of playing with them, etc.):

Paranoid thinking:

Hearing voices or seeing things that are not there:

Loss of memory for a period of time:

Legal History

Is the patient involved in any current legal proceedings? Yes No

If yes, please explain.

Any ongoing divorce or child custody proceedings in immediate the family? Yes No

If yes, please explain.

Does the patient have any pending juvenile/legal charges? Yes No

If yes, please explain.

Are the services you are seeking here court ordered? Yes No

If yes, please explain.

If receiving assessment services, do you plan on using the testing report in legal proceedings? Yes No

If yes, please explain.

Additional information: