

INITIAL INTAKE EVALUATION

Name of Person Completing Form	
Date	
Relationship to Child	
How did you hear about the practice?	
Best Contact Number	
Emergency Contact Name & Phone Number	

PATIENT INFORMATION

Patient Name	
DOB	
Age	
Ethnicity	
Gender	
Address	
Primary Care Physician (Name, Phone, Address)	

FAMILY INFORMATION

Name	Age	Relation to Patient (Bio Dad, Adoptive Mom, Sister, etc.)	Living in the Home?

PARENT/GUARDIAN MARITAL STATUS

Biological or Adoptive Parent #1 : _____
(name)

- Married Divorced Remarried Lives with Partner

Biological or Adoptive Parent #2: _____
(name)

- Married Divorced Remarried Lives with Partner

PATIENT MENTAL HEALTH HISTORY

	Date(s)	Details
Previously Received Counseling?		
Previous Psychological or Neuropsychological Testing?		
Previous Psychiatric Hospitalization?		
History of self-injurious behavior?		
History of suicide attempt(s)?		

FAMILY MENTAL HEALTH HISTORY

Family Member Name	Relationship to Patient	Diagnosis/Problems

BIRTH HISTORY

In utero exposure to any of the following:

- Alcohol Drugs Tobacco Prescription Medication

Difficulties during pregnancy?

Difficulties during birth?

Problems immediately after birth?

MEDICAL HISTORY

Allergies	
Loss of Consciousness	
Current medical issues	
Major accidents or injuries	
Major surgeries	

FAMILY MEDICAL HISTORY

Family Member	Relationship to Parent	Medical Diagnosis

CURRENT MEDICATIONS

Medication	Dose	Prescribing Physician

DEVELOPMENTAL INFORMATION

Developmental Milestone	Age Achieved (Estimate)	Ongoing Problems?
Sitting up independently		
Crawling		
Standing		
Walking		
Single Words Spoken		
Sentences Spoken		

PAST OR PRESENT DIFFICULTIES

	Past Problems?	Current Problems?
Toileting		
Eating		
Sleeping		
Vision		
Hearing		
Sensory		

EDUCATIONAL INFORMATION

Name of School and Current Grade	
Does your child have an IEP or 504 Plan?	
History of Learning Disabilities?	
Grades on Last Report Card?	
History of being Suspended or Expelled from school?	

SOCIAL HISTORY

Gets along with peers?	
Friends outside of school?	
History of bullying?	
Aware of alcohol or drug abuse?	
Extracurricular Activities?	

PRESENTING PROBLEM/CURRENT CONCERNS

Please indicate which of the following prompted you to seek treatment:

- | | | |
|--|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Suicidal Ideation |
| <input type="checkbox"/> Self-injurious Behavior | <input type="checkbox"/> Medication Refusal | <input type="checkbox"/> Poor Medical Adherence |
| <input type="checkbox"/> Overwhelmed with New Medical Diagnosis or Injury | <input type="checkbox"/> Problems Managing Chronic Pain | <input type="checkbox"/> Anxiety with Medical Procedures or Treatment |
| <input type="checkbox"/> Poor Medical Prognosis | <input type="checkbox"/> Family Conflict | <input type="checkbox"/> School Difficulties/Refusal |
| <input type="checkbox"/> Behavioral Changes after Brain surgery/Brain Injury | <input type="checkbox"/> Peer Conflict/Bullying | <input type="checkbox"/> Feeding Difficulties |

History of Problem/Concerns	
When did problems start?	
What makes problems better?	
What makes problems worse?	
Consequences suffered due to problem/concerns?	

Please identify your child's/teen's strengths:
