Capital Area Psychiatric Associates, P.L.L.C.
Child, Adolescent, and Adult Psychiatry

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COMPREHENSIVE INTAKE FORM

I. FAMILY INFORMATION

Patient's Name _____ Patient's DOB _____ Race/Ethnicity_____

Address (street, city, state, zip code) _____

Home Phone _____ Cell Phone _____

Mother's Name _____ Patient's DOB _____ Race/Ethnicity_____

Address (street, city, state, zip code) _____

Home Phone _____ Cell Phone _____

Father's Name _____ Patient's DOB _____ Race/Ethnicity_____

Address (street, city, state, zip code) _____

Home Phone _____ Cell Phone _____

Guardian's Name _____ Patient's DOB _____ Race/Ethnicity_____

Address (street, city, state, zip code) _____

Home Phone _____ Cell Phone _____

Insurance Information

Primary Insurance_____ Primary Policy #_____

Secondary Insurance _____ Secondary Policy # _____

Insurance Company's Phone/Fax # _____

In case of emergency, who should be contacted (name and phone) _____

_____

Please provide the following information on each person living in your home:

Name	Age	Relationship	Highest Grade or Degree
_____	_____	_____	_____
_____	_____	_____	_____

Are there any important people or other family members that do not live in the home that are important in your child's (patient's) life? _____

Have there been any significant changes in the family over the past five years (i.e. deaths, divorce, homelessness, job loss, etc…) _____

If there were any significant changes in the family, how did your child (patient) respond? _____

Have you or your child ever been involved with any Social Services Agency or Law Enforcement Agency? If so, please list the circumstances, contact person, and his/her phone number. _____

Are there any cultural or religious influences in your family? _____

How does your child (patient) get along with family members and other adults? _____

Please fill in the following information concerning family employment:

	Mother (or primary care provider)	Father (or other care provider)
Type of Work		
Place of Work		
Hours of Work		
Work Phone		

Please describe the home atmosphere in which you grew up. Specifically, focus on your relationship with your parents and how your parents interacted with the children in the family.

Mother (or primary care provider) _____

Father (or primary care provider) _____

Has anyone on either side of the family ever had problems with alcohol or drug addiction? If so, please explain: ___

Has anyone on either side of the family ever been diagnosed with a mental illness such as depression, bipolar disorder, dementia, anxiety disorders, schizophrenia, or attention deficit hyperactivity disorder? If so, please explain. _____

Has anyone on either side of the family ever had a medical illness such as stroke, diabetes, heart attack, sudden death before age 40, etc…? If so please explain.

Has anyone on either side of the family ever had problems with school? If so, please explain.

II. CONCERNS:

Please describe your concern(s) about your child (patient)?

When and for how long do you think these difficulties developed? _____

_____

_____

_____

Please describe any previous treatments that led to improvement or worsening of the above concerns? _____

_____

_____

_____

_____

_____

_____

What goals do you have for treatment? _____

_____

_____

_____

_____

III. PATIENT'S MEDICAL HISTORY:

Who is your child's (patient's) medical physician? (name, address, phone, fax) _____

_____

_____

Is your child currently on medication for a medical problem? If yes, please provide the name, dosage, and reason. Please also include any over the counter medications, vitamins, or other supplements which may be used on a regular basis. _____

_____

Name of Pharmacy, location, phone number, and fax number _____

Does your child have any allergies to medications or food? If yes, please explain. _____

Has your child ever been hospitalized for a medical reason? If yes, please provide why, when, how long, and where? _____

Has your child (patient) ever been had a hearing test and/or speech therapy? If yes, please provide the results and any recommendations? _____

Has your child ever used tobacco, (illicit) drugs, or alcohol? If yes, please explain (amount, frequency, duration of use, duration of sobriety, and/or any history of withdrawal difficulties like seizures or DTs). _____

Has your child ever been in a substance abuse treatment program, including AA/NA, rehab, detox, or inpatient program? If yes, please provide, when, for how long, and where. _____

Does your child have a history of head injury, loss of consciousness, and/or seizures? If yes, please explain. _____

Do any of your other children or immediate family members have medical problems? If yes, please explain. _____

IV. PATIENT'S PSYCHOLOGICAL HISTORY:

Has your child ever had outpatient psychiatric treatment? If yes, provide why, when, how long, where, and the name of the treating social worker, therapist, psychologist, or psychiatrist. _____

Has your child ever been hospitalized for psychiatric treatment? If yes, please provide why, when, for how long, and the name of the facility. _____

Is your child currently on any psychiatric medication? If yes, please provide the name(s), dose, and reason. _____

Are there any psychiatric medications that your child took in the past but is no longer taking? If yes please provide the name, dose, duration of use, and reason for discontinuation. _____

Does your child ever experience any side effects from any of the above medications? (i.e. weight gain, weight loss, nausea, vomiting, stomachache, drowsiness, difficulty sleeping, poor appetite, rash, abnormal movements, restlessness, etc…) _____

Has your child ever purposely injured himself/herself? If yes, please describe when, how, and the treatment. _____

Has your child ever been a victim of or witness to a traumatic event(s) in which his/her life was threatened or perceived to be threatened? If so, please explain how your child responded to the event and whether there were any changes in your child's behavior either brief or recurring following the event (s). _____

Has your child ever been a victim of abuse? (i.e. physical, sexual, mental, or a victim of neglect) If so, please explain the type(s) of abuse, duration, suspected perpetrator, whether the abuse was reported, whether social service agencies were involved, and the outcome of any agency investigation. _____

Does/Did your child have any legal difficulties in which charge(s) were filed against you? If so, please explain the nature of the charge(s) and how such charge(s) were resolved (i.e. incarceration, probation, trial pending, etc…) ___

V. Pregnancy (For Care Providers of Child and Adolescent Patients Only):

How old was the child's mother at delivery _____ Did the child's mother have prenatal care? _____

Were there any complications during the pregnancy? (i.e. hypertension, bleeding, infection, etc…) If yes, please explain. _____

Did the child's mother use tobacco, alcohol, or drugs during the pregnancy? If yes, please explain. _____

_____

Did the child's mother use any prescribed medication during the pregnancy? If yes, please explain. _____

_____

How was the child delivered (i.e. natural, cesarean, breech) and were there any complications? (i.e. low birth weight, premature, etc…) _____

_____

What was the duration of labor _____ What was the birth weight? _____

Did the child have any difficulties after delivery? (i.e. jaundice, withdrawal, infection, need for oxygen, surgery, blood transfusion, etc…) _____

_____

VI. Development (For Care Providers of Child and Adolescent Patients Only):

Did your child have any complications with feeding/nursing as a newborn? If yes, please explain. _____

_____

Any history of elevated blood lead levels and/or prolonged exposure to environmental toxins following birth? If yes, please explain. _____

_____

Were there any suspected delays in the achievement of early developmental milestones? (i.e. walking, talking, toilet training, etc…) If so, please explain. _____

_____

How would you describe your child's behavior and temperament as an infant? (i.e. level of activity, difficulty to soothe, ability to relate to others, etc…) _____

_____

_____

Did your child have any prolonged sleeping problems as an infant? If yes, please explain. _____

_____

VII. School Information (For Care Providers of Child and Adolescent Patients Only):

Name of preschool (s) _____ Ages attended _____

Significant experiences, accomplishments, or problems _____

_____

Name of elementary school (s) _____ Ages attended _____

Significant experiences, accomplishments, or problems _____

_____

Name of middle school (s) _____ Ages attended _____

Significant experiences, accomplishments, or problems _____

_____

Name of high school (s) _____ Ages attended _____

Significant experiences, accomplishments, or problems _____

_____

Were there any special education services received? (i.e. need to repeat a grade, change in classroom placement, need for IEP/504 plan, etc…) If yes, which grades and what type of services were provided? _____

_____

_____

VIII. HOME/SOCIAL ACTIVITIES (For Care Providers of Child and Adolescent Patients Only):

Does your child have any chores? If yes, please explain. _____

_____

What time does your child go to bed and are there any problems with sleep? (i.e. nightmares, frequent awakening, sleeping in your bed, sleep walking, bedwetting, watching television, etc.) _____

_____

_____

Do you have any concern about your child's eating habits? If so, please explain. _____

_____

How is discipline handled in the home? _____

_____

Does your child participate in any clubs, organizations, or athletic teams? If so, please explain. _____

_____

_____

Does your child have any hobbies or special interests? If so, please explain. _____

_____

Does your child have a part-time job/summer job? Were there any difficulties with current or previous employers?

If so, please explain. _____

_____

Does your child have any previous or current legal difficulties? If so, please explain. _____

_____

Thank you for your thoughtful responses.

This intake form has been completed by (NAME) _____

My relationship to the patient is (i.e. mother, father, legal-guardian, etc…) _____

Signature and Date _____