Sutter Health
Palo Alto Medical Foundation

PATIENT LABEL

DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL HEALTH CHILD/ADOLESCENT INTAKE FORM

Completed by:_____

Child's Name_____ SEX: ☐ M ☐ F Age: _____ Date of Birth:_____

Ethnicity: _____ Adopted/Custody: Yes ☐ No ☐ Explain:_____ Place of Birth:_____

Parent's or Guardian's Name_____

Address:_____

Home phone:_____ Work phone:_____ Cellular phone:_____

Parents are: ☐ single ☐ married ☐ separated ☐ divorced ☐ remarried ☐ widowed ☐ cohabitating

If divorced, what are the custody arrangements?_____*(Please bring copy of custody agreement for the chart)*

Please give other parent's address and phone number.

Name_____

Address:_____

Home phone number:_____ Work phone number:_____

Name of Physician(s):_____ Phone number:_____

Psychiatrist/other Professional:_____ Phone number:_____

HOUSEHOLD MEMBERS

Name	Age	Relationship	Occupation/Grade

FAMILY MEMBERS NOT LIVING IN HOUSEHOLD (e.g., stepchildren, adult children, etc.)

Name	Age	Relationship	Occupation/Grade

AREAS OF CONCERN (check all that apply):

Personal/Social Adjustment:

- ☐ Unduly sad
- ☐ Overly anxious
- ☐ Overly aggressive
- ☐ Temper tantrums
- ☐ Withdrawn or shy
- ☐ Disturbing habits or mannerisms
- ☐ Strange or bizarre behavior
- ☐ Problems in peer relationships
- ☐ Drug or alcohol problems
- ☐ Problems with the law
- ☐ Harms self or others (suicidal or homicidal)
- ☐ Other (please specify):

_____
_____
_____

Family Adjustment

- ☐ Parent-child problems
- ☐ Marital conflict or coparenting problems
- ☐ Sibling conflict
- ☐ Recent family changes
- ☐ Neighborhood difficulties
- ☐ Mother experiencing difficulties
- ☐ Father experiencing difficulties
- ☐ Sibling experiencing difficulties
- ☐ Drug or alcohol problems in family
- ☐ History of trauma or loss
- ☐ Domestic violence
- ☐ Abuse
- ☐ Other (please specify):

_____
_____
_____

School Adjustment

- ☐ Academic problems
- ☐ Difficulty with peers
- ☐ Difficulty with authority
- ☐ Attendance problems or reluctance to go to school
- ☐ Behavior problems
- ☐ Learning disabilities
- ☐ Attentional problems
- ☐ Aches and pains related to school
- ☐ Other (please specify):

_____
_____
_____

Physical/Developmental Factors

- ☐ Eating
- ☐ Sleeping
- ☐ Toileting
- ☐ Grooming
- ☐ Language or speech
- ☐ Perceptual/visual functions
- ☐ Motor coordination problems
- ☐ Other, (please specify):

_____
_____
_____

HISTORY OF CURRENT PROBLEM

Duration and primary concern (include changes in mood, behavior, sleep, eating, free time activities, school concerns). Please use backside of page for important history.

What have you already done to address this concern and how effective were these efforts?

Was there an event that caused you to seek treatment now? ____ If yes, please describe.

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SCHOOL HISTORY

Current grade level:_____ Current school:_____ Teacher's name:_____

School address:_____ Phone:_____ Fax:_____

Please summarize child's progress (e.g., academic, social), within each of these grade levels:

Preschool

Kindergarten

Grades 1 - 3

Grades 4 – 5

Grades 6-8

Grades 9-12

Has child ever been evaluated? _____ School Study Team (SST)_____ Individualized Educational Program (IEP)_____
What was the outcome of the evaluation? Accommodations?

		Date
Learning disabilities class	_____	_____
Behavioral/emotional disorders class	_____	_____
Resource room	_____	_____
Speech & language therapy	_____	_____
Suspended, expelled, retained	_____	_____
Other (please specify):	_____	_____

Other evaluations: Psychological, Educational, Speech, Occupational Therapy
(please bring copies to the intake evaluation).

Type of evaluation	Name and phone number of evaluator	Date of exam	Outcome

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PAST PSYCHIATRIC HISTORY: Check those that apply.

Outpatient psychotherapy: Yes ___ No ___

Family therapy___ How long:_____ Individual therapy___ How long?_____ Group therapy___ How long?_____

Inpatient (Hospital or Residential): Yes ___ No___ If yes, where and when?_____

Past suicidal ideation? Yes ___ No ___ Plan? Yes ___ No ___ Number of attempts and dates:_____

Current suicidal ideation? Yes ___ No ___ Plan? Yes ___ No___ Most recent attempt date:_____Method:_____

Previous diagnosis:_____

Name of treating Psychotherapist or Psychiatrist:_____

Address:_____ Phone number:_____ FAX number:_____

MEDICAL HISTORY:

Any significant or relevant medical problem (e.g. allergies, asthma, accidents & dates, surgery & dates, abuse & dates):

_____

_____

Chronic condition or disability:_____

Medications of any kind child is currently taking:

Medication	Dosage	Frequency	Purpose

Has child had an allergic reaction or other problems with medications? Yes___ No___

If yes, which drugs, and briefly explain:_____

_____

HABITS (list amounts and frequency):

Alcohol or Drugs:_____ Caffeine:_____

Vitamins:_____ Herbal Supplements:_____

Exercise (amount,/type/frequency):_____

Sleep:_____ Eating:_____

Other:_____

FAMILY OF ORIGIN HISTORY

Please list below family member(s) who have (or had) emotional problems, depression, anxiety, psychiatric illness, drug or alcohol abuse, attentional difficulties, learning disabilities, autism, developmental delays or cognitive disabilities, abuse, neglect, suicide attempts, etc.

Family Member (relationship to child)	Problem	On-going	Resolved

DEVELOPMENTAL FACTORS

A. Prenatal History

1. Mothers health during pregnancy was: Good ☐ Fair ☐ Poor ☐

2. Age of mother at child's birth?
   Under 20 ☐ 20-24 ☐ 25-29 ☐ 30-34 ☐ 35-39 ☐ 40-44 ☐ Over 44 ☐ Unknown ☐

3. Did mother use any of these substances or medications during pregnancy?

Beer/wine:	☐ Never,	☐ once or twice,	☐ 3 – 9 times,	☐ 10 – 19 times,	☐ 20 – 39 times,	☐ 40+ times
Coffee/caffeine:	☐ Never,	☐ once or twice,	☐ 3 – 9 times,	☐ 10 – 19 times,	☐ 20 – 39 times,	☐ 40+ times
Hard liquor:	☐ Never,	☐ once or twice,	☐ 3 – 9 times,	☐ 10 – 19 times,	☐ 20 – 39 times,	☐ 40+ times
Cigarettes:	☐ Never,	☐ once or twice,	☐ 3 – 9 times,	☐ 10 – 19 times,	☐ 20 – 39 times,	☐ 40+ times
Tranquilizers (Sleeping pills)	☐ Never,	☐ once or twice,	☐ 3 – 9 times,	☐ 10 – 19 times,	☐ 20 – 39 times,	☐ 40+ times
Other:_____	☐ Never,	☐ once or twice,	☐ 3 – 9 times,	☐ 10 – 19 times,	☐ 20 – 39 times,	☐ 40+ times

4. Did mother have toxemia or eclampsia? No ☐ Yes ☐

5. Was there Rh factor incompatibility? No ☐ Yes ☐

6. Child born on schedule?_____, If early, how premature_____

7. Duration of labor?_____

8. Fetal distress during labor? No ☐ Yes ☐

9. Was delivery: Normal ☐ Breech ☐ Caesarian ☐ Forceps ☐ Suction ☐ Induced ☐

10. Child's birth weight? _____ APGAR Score _____

11. Were there complications following birth? No ☐ Yes ☐

    If yes, what were they? _____

B. Postnatal Period / Infancy / Toddler

1. Feeding problems No☐ Yes☐
2. Colic? No☐ Yes☐
3. Sleep pattern difficulties? No☐ Yes☐
4. Problems with responsiveness (alertness)? No☐ Yes☐
5. Were there health or congenital problems during infancy? No☐ Yes☐
6. How was it to care for this child? Very easy☐ easy☐ average☐ difficult☐ very difficult☐
7. How did the child behave with other people?
   More sociable than average☐ average sociability☐ more unsociable than average☐
8. When the child wanted something, how insistent was (s)he?
   Very insistent☐ somewhat insistent☐ average☐ not very insistent☐ not at all insistent☐
9. Rate the activity level of the child: Very active☐ active☐ average☐ less active☐ not active☐

C. Developmental Milestones

1. Age child sat up: 3-6 months☐ 7-12 months☐ Over 12 months☐
2. Age child crawled: 6-12 months☐ 13-18 months☐ Over 18 months☐
3. Age child walked alone: Under 1 year☐ 1-2 years☐ 2-3 years☐
4. Age child spoke single words other than ‘mama’ or ‘dada’?
   9-13 months☐ 14-18 months☐ 19-24 months☐ 25-36 months☐ 37-48 months☐
5. Age child strung two or words together:
   9-13 months☐ 14-18 months☐ 19-24 months☐ 25-36 months☐ 37-48 months☐
6. Age toilet trained?
   Bladder controlled: Under 1 year☐ 1-2 years☐ 2-3 years☐ 3-4 years☐ 4+ years☐
   Bowel controlled: Under 1 year☐ 1-2 years☐ 2-3 years☐ 3-4 years☐ 4+ years☐
7. How long did toilet training take from onset to completion?
   Less than 1 month☐ 1-2 months☐ 2-3 months☐ More than 3 months☐