Bridge to Wellness Centers LLC

Child & Adolescent Intake

Please bring the completed form to your *first* visit to expedite the evaluation process

Name of Person Completing Form: _____Today's Date: _____

Child's Name: _____ Child's DOB: _____

Child's Race: _____ Grade: _____

Family Members residing with child	**Relationship**	**Age**

Please describe the *main* issue that led to you seeking treatment:

_____

_____

_____

What specific goals would you like to achieve by being seen here? _____

_____

_____

MEDICAL/TREATMENT HISTORY

1. History of Psychological/Psychiatric Treatment

a. Has your child ever received any outpatient treatment or evaluations for any emotional, behavioral, substance abuse, or personal difficulties? ❑ Yes ❑ No

Date Clinic Name of Provider Reason

_____

_____

_____

_____

b. Has your child ever been hospitalized for anxiety, depression, substance use, or any other emotional or behavioral problem? ❑ Yes ❑ No

Date Hospital Reason

_____

_____

_____

c. Is your child *currently* taking any medications for anxiety, depression, or any other emotional problem (include sleep medication)? ❑ Yes ❑ No

Date Clinic Doctor Reason Medication/Dose

_____

_____

_____

_____

d. Has your child *previously* taken any medications for anxiety, depression, or any other emotional problem (include sleep medication)? ❑ Yes ❑ No

2. Date Clinic Doctor Reason Medication/Dose

_____

_____

_____

_____

If *current* or *past* history of psychotropic medication use:

a. Have you ever experienced problems with these medications such as side effects, withdrawal problems, etc.? ❑ Yes ❑ No

If *yes*, specify: _____

2. Medical History

b. Child's height? _____ b. Child's weight? _____

b. Is your child currently being treated for any physical disease or condition? ❑ Yes ❑ No

If *yes*, specify: _____

c. Has your child ever had to be hospitalized for a physical problem? ❑ Yes ❑ No Date
Reason

_____

_____

d. Has your child ever had a surgical procedure? ❑ Yes ❑ No Date Reason

_____

_____

e. Has your child ever had a concussion or any head injury? ❑ Yes ❑ No
Date Reason Loss of consciousness?

_____

_____

f. Does your child have any allergies? ❑ Yes ❑ No
If *yes*, specify: _____

FAMILY HISTORY: FATHER

Age _____ Occupation_____

Highest grade completed _____

Learning or Behavior problems (specify) _____

Medical problems (specify) _____

_____

Has the child's father or any of his first degree (parent, sibling, child) blood relatives ever had problems similar to those your child has or other psychiatric/psychological conditions? If so, describe (who, what).

_____

_____

_____

FAMILY HISTORY: MOTHER

Age _____ Occupation_____

Highest grade completed _____

Learning or Behavior problems (specify) _____

Medical problems (specify) _____

_____

Has the child's mother or any of her first degree (parent, sibling, child) blood relatives ever had problems similar to those your child has or other psychiatric/psychological conditions? If so, describe (who, what).

_____

_____

_____

_____

PREGNANCY (this information pertains to the mother of the child being seen)

Were there any complications during pregnancy? If so, specify:

_____

_____

_____

Smoking during pregnancy? ❑ Yes ❑ No

If yes, average number of cigarettes per day

Alcoholic consumption during pregnancy? ❑ Yes ❑ No

Describe, if any beyond an occasional drink _____

Medication(s) taken or other toxin (mercury, lead, etc.) exposure during pregnancy _____

_____

X-ray studies during pregnancy _____

DELIVERY AND POST DELIVERY

Delivery on time? ❑ Yes ❑ Early (How early)?_____ ❑ Late (how late?) _____

Type of labor: ❑ Spontaneous ❑ Induced

Forceps: ❑ Yes ❑ No
Type of delivery: ❑ Normal ❑ Breech ❑ Cesarean
Birth Weight: ____ pounds ____ ounces
Total number of days baby was in hospital after delivery:_____

Describe any complications during delivery (cord around neck, injuries, etc.) or post delivery (jaundice, incubator care, birth defects, respiration,etc.) _____

_____

_____

INFANCY-TODDLER PERIOD (If any of the following were present to a significant degree during the first few years of life, please check yes and describe briefly.)

b. Did not enjoy cuddling ❑ Yes ❑ No
Describe _____

g. Was not calmed by being held and/or stroked ❑ Yes ❑ No
Describe _____

h. Colic ❑ Yes ❑ No
Describe _____

i. Excessive restlessness ❑ Yes ❑ No
Describe _____

j. Diminished sleep due to restlessness/easy arousal ❑ Yes ❑ No
Describe _____

k. Frequent head-banging ❑ Yes ❑ No
Describe _____

l. Constantly into everything ❑ Yes ❑ No
Describe _____

m. Excessive number of accidents compared to other children ❑ Yes ❑ No
Describe _____

n. Excessive fears compared to other children ❑ Yes ❑ No
Describe

DEVELOPMENTAL MILESTONES

Milestone	*Age*	*Early*	*Normal*	*Late*	*?*
Walked without assistance					
Spoke first words (besides ma-ma and da-da)					
Said phrases					
Potty trained (day)					
Potty trained (night)					
Said alphabet in order					
Rode bicycle (without training wheels)					
Buttoned clothing					
Tied shoelaces					
Named colors					
Began to read					

Comments? _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age? ❑ Yes ❑ No If no, why?

_____

How would you rate your child's overall level of intelligence compared to other children?
❑ Below Average ❑ Average ❑ Above Average

SCHOOL

Rate your child's school experience related to:

	Academic learning			***Peer/social experience***		
	Good	***Average***	***Poor***	***Good***	***Average***	***Poor***
Nursery school						
Kindergarten						
Elementary school						
Middle/Junior High						
High School						

Has your child ever had to repeat a grade? ❑ Yes ❑ No
If so, when? _____

Present class placement: ❑ Regular class ❑ Special Class (specify)

Kinds of special therapy or remedial work your child is currently receiving:_____

_____

Briefly describe any academic problems:_____

_____

_____

Briefly describe any behavioral problems at school:_____

_____

_____

PEER RELATIONSHIPS

Does your child seek friendships with others Yes _____ No _____
Is your child sought by peers for friendship? Yes _____ No _____
Does your child play mostly with children his/her own age? Yes ___ No ___
If no, are playmates: older _____ younger __

Briefly describe any problems your child may have with peers.

HOME BEHAVIOR

To some degree, all children exhibit some degree of behavior problems. Please describe those which you believe your child exhibits to an excessive degree when compared to other children his/her age or those you believe to be problematic_____

_____

SYMPTOM LIST

At one time or another, most children exhibit one or more of the symptoms listed below. Please check if your child has exhibited any of these symptoms in the past or exhibits currently.

Mark only those symptoms which have been to a significant degree over a period of time. Check only problems which you suspect are unusual when compared to other children of the same age.

Problem	***Past***	***Now***	***Comments***
Immature			
Frequent temper tantrums			
Aggression (physical or verbal)			
Hyper, unable to sit still			

Procrastinates			
Excessive silliness or clowning			
Eats non-edible substances			
Eats too much or too little			
Excessive demands for attention			
Works too hard			
Suspicious, distrustful			
Suicidal or self-injurious behavior			
Poor motivation			
Brags or boasts			
Perfectionism			
Walking or talking in sleep			
Nightmares			
Night terrors			
Insomnia or other sleep difficulties			
Inappropriate sexual behavior			
Enuresis (wetting)			
Encopresis (soiling)			
Refuses to try new things			
Back talks			
Oppositional and/or defiant			
Destruction of property			
Cruelty toward animals			
Stealing			
Frequent use of profanity			
Argumentative			
Persistent lying or cheating			
Extreme response if does not get own way			
Sore loser			
Criminal/dangerous acts			
Substance use			
Runs away from home			
Sneaks out			
Stays out past curfew			
Selfish			

Violent outbursts of rage			
Lacks guilt or remorse			
Disrespectful			
Always complaining			
Bullying or teasing			
Very stubborn			
Annoys others on purpose			
Nervous mannerisms, tics, twitches			
Involuntary grunts or vocalizations			
Repetitive/compulsive behaviors			
Poor attention/concentration			
Disorganized			

Problem	***Past***	***Now***	***Comments***
Strange ideas			
Feels others are persecuting him/her			
Excessively competitive			
Excessive self-criticism			
Excessive laziness			
Extremely forgetful			
Loses things frequently			
Excessive fidgeting			
Hair pulling, nail biting, skin picking,			
Head banging			
Speaks rapidly and under pressure			
Talks too much			
Impulsive			
Excessively irritable			
Blames others for mistakes or behavior			
Poor tolerance of criticism			
Stuttering			
Excessive desire to please others			
Passive and easily led			
Little concern for hygiene			

Refuses to speak			
Unwanted thoughts, upsetting images			
Sees or hears things others don't			
Appears to be in own world			
Staring spells			
Low energy			
Irresponsible			
Incomprehensible speech			
Excessively critical, cynical, negative			
Fixation or preoccupation			
Difficulty making decisions			
Sensitivity to noise, light, tactile/textures			
Restricted variety of foods			
Emotions			
Excessive fears (specify)			
Frequent worrying (specify)			

Problem	***Past***	***Now***	***Comments***
Negative self-esteem			
Negative body image			
Severe mood swings			
Elated mood, Euphoria			
Depression, sadness			
Loss of interest, bored			
Thoughts of suicide, death, dying			
Cries frequently and easily			
Overly sensitive			
Excessive guilt			
Flat emotional tone			
Withdrawn			
Pouts/sulks			
Physical			
Frequent headaches			
Frequent stomachaches			

Other aches and pains			
Social			
Shy			
Few, if any, friends			
Poor eye contact			
Communication difficulties			
Socially awkward			
Aloof			
Academic			
Truancy from school			
Poor grades			
Fails to complete assignments			
Disruptive			
Defiant			
Excessive detentions			
Suspensions or Expulsion			
Test anxiety			

ADDITIONAL REMARKS_____

_____

_____

_____

_____