JEFFERSON COMMUNITY Health & Life

Child/Teen Psychiatry Intake Form

Patient Name: DOB:

Name of Person Completing Form: Relationship to Child:

Phone number for Person Completing Form: _____

Custody Arrangement in place or other court documents: *Please bring these documents to the appointment if applicable.

Primary Physician: Preferred Pharmacy:

Preferred Name (nickname):

Who referred to the clinic for services:

Service(s) sought: ☐ Therapy ☐ Medication Management ☐ Not sure

Allergies: ☐ No Known Medication Allergies ☐ No Known Environmental or Food Allergies

List allergies and describe the reactions:

Allergy	Reaction

Date of Last Exam/Screening: Well child/Sports physical - Dental-

Hearing- Eyes/Vision-

Medications: (List Names of Medications, Supplements/Vitamins with Dosage and Frequency) ☐ None

If you have a list, please give it to nursing staff.

Medication	Dosage	Frequency

Females only:

Your age when menses/monthly periods started? _____ Are your periods ☐ Regular ☐ Irregular ☐ N/A

Are you currently pregnant? ☐ No ☐ Yes Do you have plans for pregnancy within 6-12 months? ☐ No ☐ Yes

Number of pregnancies? _____ Number of live births? _____

Birth control used? ☐ None ☐ Pills/Injection/IUD/Implant/Barrier (circle all that apply)

Surgeries: Please list any surgeries and the approximate date performed.

Surgery Type	Approximate Date Performed

Patient Medical History? *(Check all that apply.)*

☐ Anxiety/Depression	☐ GERD/Ulcers	☐ Lung Disease
☐ Asthma	☐ Heart Disease	☐ Frequent headaches/Migraines
☐ Arthritis/Fibromyalgia	☐ High Blood Pressure	☐ Skin Problems
☐ Atrial Fibrillation	☐ High Cholesterol	☐ Sleep Apnea/CPAP
☐ Bipolar Disorder/Schizophrenia	☐ HIV	☐ Stroke/TIA
☐ Blood Clots/DVT	☐ Kidney Failure	☐ Thyroid Disease
☐ Diabetes	☐ Liver Disease	☐ Weight Gain/Loss
☐ Hearing deficit/hearing aids	☐ Seizure disorder/Epilepsy	☐ Significant head injury/multiple concussions
☐ Vision problems/wears glasses		

Family History? *(Check all that apply and place the letter corresponding to the family member.)*

M=Mother F=FATHER S=SISTER B=BROTHER

MEDICAL HISTORY:	MENTAL HEALTH HISTORY:
☐ Bleeding Disorder _____	☐ Anxiety Disorder _____
☐ Cancer/Type _____	☐ Attention Deficit Hyperactivity Disorder _____
☐ Diabetes _____	☐ Bipolar Disorder _____
☐ Heart Disease _____	☐ Depression _____
☐ Stroke _____	☐ Intellectual Disability _____
☐ Other _____	☐ Obsessive Compulsive Disorder _____
	☐ Schizophrenia _____
	☐ Substance Use Disorder _____
	☐ Survivor of Abuse/Trauma/PTSD _____
	☐ Attempted or Died by Suicide _____

Briefly explain your primary concerns for the child, including when you first noted these concerns.
(Ex: since infant, 2 years ago, 2 months ago, etc.)

_____

_____

Since you noticed the symptom(s), has there been an increase in severity and/or frequency?

☐ Worsening ☐ Improving ☐ Stayed the Same ☐ Ebb and flows (times of better and worsening)

What are your child's strengths? _____

What are your child's weaknesses/struggles? _____

When is your child happiest? _____

Does the child display any of the following behaviors/concerns? *(Mark all that apply)*

☐ Hyperactivity (overactive or can't sit still)	☐ Self-Injury (head banging, hitting, scratching, cutting self)
☐ Impulsive/risk taking	☐ Stealing
☐ Depression/frequent crying spells/loss of joy	☐ Arson (starting fires)
☐ Anxiety	☐ Being cruel to animals
☐ Mania (obsessed with big ideas, overly happy)	☐ Use or threaten use of weapons
☐ Hallucinations (seeing or hearing things others may not)	☐ Sleep concerns/nightmares
☐ Attention difficulties	☐ Appetite and/or food selectivity (picking eating) concerns
☐ Verbal aggression (shouting, screaming, cussing)	☐ Other:
☐ Physical aggression (hitting, biting, pushing, etc.)	

How well is the child doing in the following areas?

	Below Average / Very Poor	Below Average	Above Average	Average	Excellent	N/A
Grades in School	☐	☐	☐	☐	☐	☐
Behavior in School	☐	☐	☐	☐	☐	☐
Behavior at Home	☐	☐	☐	☐	☐	☐
Relationships with family	☐	☐	☐	☐	☐	☐
Relationships with peers	☐	☐	☐	☐	☐	☐
Social media & screen time use behaviors	☐	☐	☐	☐	☐	☐
Overall level of functioning	☐	☐	☐	☐	☐	☐

Family Information: (List parents/guardians and employment status; *full-time, part-time, stay at home, unemployed)*

1. _____ 3. _____
2. _____ 4. _____

Biological Parents: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Deceased

Living Situation:

☐Apartment ☐House ☐Group Home ☐In Transition/Shelter ☐Homeless ☐Foster Care ☐ Military family

Does child attend daycare? ☐ No ☐ Yes If yes, how many hours/days per week? _____

Please list those living within main household and their relationship to child.

1. _____
2. _____
3. _____
4. _____

Does child split time between multiple households? ☐ No ☐ Yes If yes, how many days/hours weekly_____

Who else regularly lives in secondary household with child? (*Name, relationship to child, how child gets along with (i.e. good, fair, poor)*

1. _____
2. _____
3. _____
4. _____

Custody/Guardianship:

Name of child's legal guardian? _____

Current custody arrangement? If yes, please explain: _____

Has child been removed from parent or primary caregiver? If yes, is there a plan for reunification, please explain:

_____

Spirituality:

Child's Religious Affiliation: _____ Church/group attended: _____

Has there been major changes/stressors in the child's life within the past year: ☐ None known ☐ Yes

If yes, please describe _____

_____

Has the child ever been involved with Child Protective Services or Foster Care? ☐ No ☐ Yes

If yes, please explain and provide caseworker information _____

_____

Developmental History: (pregnancy complications or concerns by you and/or doctor)

	No	Yes	Not sure
Pregnancy	☐	☐	☐
Delivery	☐	☐	☐
Use of drug(s)/alcohol during pregnancy	☐	☐	☐
Tobacco use during pregnancy	☐	☐	☐
High blood pressure during pregnancy	☐	☐	☐
Other Concerns:	☐	☐	☐
If you answered yes to any of the above, please briefly describe:			

Milestones:

(Please indicate if child met following milestones as delayed, average, above average, or unknown)

	Delayed	Average	Above Average	Unknown
Sat alone (6-8 months)	☐	☐	☐	☐
Crawled (9 months)	☐	☐	☐	☐
Walked (12-18 months)	☐	☐	☐	☐
Feed Self (10-12 months)	☐	☐	☐	☐
First Spoke (10 months)	☐	☐	☐	☐
Toilet Trained (2-3 years)	☐	☐	☐	☐

Does/has child experienced any of following (select all that apply)

	Yes	No	Unsure
Unusually fussy, difficult to console, or easily startled as an infant	☐	☐	☐
Expresses distress during grooming, baths, nail cutting, haircuts, brushing hair	☐	☐	☐
Prefers long-sleeved clothing when it is warm or short-sleeved when it is cold	☐	☐	☐
Limits or avoids tastes, smells, touch, textures, or temperatures	☐	☐	☐
	Yes	**No**	**Unsure**
Becomes anxious or distress when feet leave the ground	☐	☐	☐
Is clumsy, falls frequently, bumps into things	☐	☐	☐
Doesn't seem to notice or overly avoids when face or hands are messy	☐	☐	☐
Leaves clothing twisted or bunched on body or will not allow this	☐	☐	☐
Is distracted or has trouble if there is a lot of noise	☐	☐	☐
Does not respond when name is called but you know the child's hearing is OK	☐	☐	☐
Tires easily, especially when standing or hold a particular body position	☐	☐	☐
Responds negatively or puts hands over ears to unexpected or loud noises *(cries or hides from vacuum cleaning, dog barking)*	☐	☐	☐
Is bothered by lights after others have adapted *(covers eyes/squints to protect from light)*	☐	☐	☐
Finds it difficult to make friends with peers; prefers to play with adults or younger children	☐	☐	☐
Has difficulty learning new motor tasks; experiences frustration when trying to follow instructions or sequence steps for an activity	☐	☐	☐
Uses an inappropriate amount of force when handing objects, coloring, writing or interacting with siblings or pets	☐	☐	☐
Other Concerns, please describe:			

Other Areas of Concern: ☐ None

(Did child meet following development milestones as normal, delayed, previously treated, unknown)

	Normal	Delayed	Previously Treated	Unknown
Hearing	☐	☐	☐	☐
Vision	☐	☐	☐	☐
Fine Motor Skills *(pinching, eating with fork)*	☐	☐	☐	☐
Gross Motor Skills *(running, jumping, throwing)*	☐	☐	☐	☐

List other prior evaluations/screenings, including psychological or educational evaluations. ☐ None
Please include approximate dates and locations (Educational/Special, Psychological, Psychiatric, Neurological)

_____

Educational Information:

Is the child currently in school? If yes, current grade (attending or will attend): _____

School attended: _____

Child at school: ☐ No concerns

	Yes	No	Maybe	Unsure	N/A
Disruptive behavior	☐	☐	☐	☐	☐
Learning	☐	☐	☐	☐	☐
Getting along with peers	☐	☐	☐	☐	☐
Getting along with teachers	☐	☐	☐	☐	☐
Getting along with adults in general	☐	☐	☐	☐	☐

History of any School Services Required: ☐ None

☐ Early Intervention *ex: School services prior to kindergarten*	☐ Occupational Therapy
☐ Special Education Services *ex: IEP*	☐ Physical Therapy
☐ 504 Play/Educational Accommodations	☐ Tutoring
☐ Speech Therapy	☐ Other:

Average current grades achieved: ☐ Very Poor ☐ Below Average ☐ Average ☐ Above Average ☐ Excellent

Consequences at school: (mark all that apply)**:**
☐ Frequent detention/summer make-up ☐ Current/past suspension ☐ Expelled ☐ Repeated a grade/retained ☐ Unsure

Reported Teacher Concerns: ☐ None

_____

_____

_____

Does child participate in extracurricular activities? ☐ No ☐ Yes If yes, please describe and if child is still enjoying:

_____

Does child have other interests/hobbies? ☐ No ☐ Yes If yes, please list and if child is still enjoying:
(Ex: fishing, shopping, reading, art, etc.) _____

Social Media & Screen Time

How many hours per week is the child on social media? (Television with movies and shows does not count)

☐ 0-5 hrs. weekly ☐ 5-10 hrs. weekly ☐ 10-15 hrs. weekly ☐ 15+ hrs. weekly

How many hours per week does the child play video games?

☐ 0-5 hrs. weekly ☐ 5-10 hrs. weekly ☐ 10-15 hrs. weekly ☐ 15+ hrs. weekly

What are the child's favorite apps, video games or other things they do with screen time?

_____

Do you have concerns with the child's screen time?
(Ex: amount of time, content viewed or shared, transitions away from screen time, etc.)

_____

_____

Safety & Legal Information

Has the child ever been in trouble with the law, received a citation or been charged with a crime? ☐ Yes ☐ No

If yes, please describe: _____

Is the child currently on probation or involved in any legal issues? ☐ Yes ☐ No

If yes, please describe: _____

Is child driving? ☐ Yes ☐ No If yes, for how long? _____

Do you have any suspicion that the child has ever been the victim of abuse (physical, sexual, emotional, neglect)?
☐ Yes ☐ No ☐ Unsure

Do you have any suspicion that the child has ever witnessed anyone else experience abuse (physical, sexual, emotional, neglect)? ☐ Yes ☐ No ☐ Unsure

Personal & Emotional Health History:

Does the child currently work with a counselor/therapist? ☐ Yes ☐ No If yes, who/where: _____

Has the child ever been hospitalized for mental health? ☐ Yes ☐ No

Have you ever been concerned about child self-harming? ☐Yes ☐ No If yes, please describe event/when:

_____

Are firearms easily accessible within the home/on property? ☐ Yes ☐ No

Substance Use:

Do you have any concerns about the child using drugs or alcohol? ☐ Yes ☐ No ☐ Maybe
If yes or maybe, please describe: _____

_____

Does the child have any legal consequences due to alcohol or drugs? ☐ Yes ☐ No If yes, please describe:

_____

Family History of Substance use: ☐ None
(List any immediate family members with current/remote history of substance abuse and substance used)

_____ _____

_____ _____

Additional Information:

Goals of treatment/what would you like to see change in the child?

_____

_____

_____

How would you know the child is getting better?

_____

_____

_____

Please add any additional information:

_____

_____

_____

Past medication trials (mark all that apply):

Group 1					**Describe**
amitriptyline (Elavil)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes☐No	
bupropion (Wellbutrin)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
citalopram (Celexa)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
clomipramine (Anafranil)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
desvenlafaxine (Pristiq)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
desyrel (Trazodone)	Helful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
duloxetine (Cymbalta)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
escitalopram (Lexapro)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
fluoxetine (Prozac)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
fluvoxamine (Luvox)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
mirtazapine (Remeron)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
paroxetine (Paxil)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
sertraline (Zoloft)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
venlafaxine (Effexor)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
vilazodone (Viibryd)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
vortioxetine (Trintellix, Brintellix)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Group 2 **Describe**

aripiprazole (Abilify)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes☐No	
asenapine (Saphris)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
chlorpromazine (Thorazine)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
clozapine (Clozaril)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
fluphenazine (Prolixin)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
haloperidol (Haldol)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
lurasidone (Latuda)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
olanzapine (Zyprexa)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
paliperidone (Invega)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
quetiapine (Seroquel)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
risperidone (Risperdal)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
thioridazine (Mellaril)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
thiothixene (Navane)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
trifluoperazine (Stelazine)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
ziprasidone (Geodon)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Group 3 **Describe**

alprazolam (Xanax)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes☐No	
buspirone (BuSpar)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
clonazepam (Klonopin)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
diazepam (Valium)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
hydroxyzine (Atarax, Vistaril)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
lorazepam (Ativan)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Group 4 **Describe**

Amphetamine (Dexedrine)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Amphetamine/dextroamphetamine (Adderall, Adderall XR)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Atomoxetine (Strattera)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Dexmethylphetamine (Focalin, Focalin XR)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
Dextroamphetamine (Dexedrine, Dexedrine ER, Zenzedi)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Guanfacine (Tenex), Guanfacine ER (Intuniv)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
Lisdexamfetamine (Vyvanse)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Methylphenidate (Ritalin, Ritalin SR, Concerta Metadate, Metadate CD, Daytrana Patch, Quillivant XR)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Group 5					**Describe**
carbamazepine (Tegretol)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
Depakote (Divalproex Sodium)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
gabapentin (Neurontin)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
lamotrigine (Lamictal)	Helpful?	☐Yes☐No	Side Effects?	☐Yes ☐No	
lithium (Lithobid)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
oxcarbazepine (Trileptal)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	
topiramate (Topamax)	Helpful?	☐Yes ☐No	Side Effects?	☐Yes ☐No	

Patient Name: _____ Gender/Identifier: ☐ Male/he/him ☐ Female/she/her ☐ Nonbinary/they/them

(To be filled out by the client aged 13-18 years old)

Disclaimer: Here are some questions that will help us get to know and what may impact your health, safety, and well-being. We ask these questions of everyone your age. Your privacy is extremely important to us. Please answer the questions as honestly as possible. Keep in mind that your safety is our top priority. We do not want anyone to get in trouble, but if we think that you or someone else could be hurt, we must let someone know. You can decide to talk to us in person about these questions too and if so, answer, "prefer in person" in each section. Please let us know if you have any questions about this form.

Was it your idea to come to talk about your mental health? How exactly did you or the other person decide it was time to come?

_____

_____

How do you feel about coming to this visit?

_____

_____

Please list your strengths, what you are good at and what you like about yourself.

_____

_____

Please list your weaknesses, struggles, or dislikes about yourself.

_____

_____

Do you see or hear things that are weird or scary? If yes, please describe.

_____

_____

Do you have: (*Mark all that apply)*

☐ Significant Other ☐ Best Friend ☐ Job ☐ Drive a car

☐ Weapons available to you ☐ Faith or Spiritual Beliefs that are important to you

Briefly tell me more about anything marked above:
(*Ex: good relationship with partner, work in construction and is good, Christian but question God right now)*

_____

_____

_____

Do you have issues/concerns with: (*mark all that apply*)

☐ Your parents/guardians ☐ Siblings ☐ Friends/Peer pressure ☐ Significant other/Relationship ☐ Being bullied

☐ School & Teachers ☐ Screen time and/or social media ☐ Sexual orientation/identification

Briefly describe more about item(s) listed above:

_____

_____

_____

How many hours per week do you use social media?

☐ 0-5 hrs. weekly ☐ 5-10 hrs. weekly ☐ 10-15 hrs. weekly ☐ 15+ hrs. weekly

What are your favorite apps? _____

How many hours per week do you play video games?

☐ 0-5 hrs. weekly ☐ 5-10 hrs. weekly ☐ 10-15 hrs. weekly ☐ 15+ hrs. weekly

What are your favorite games? _____

Do you have concerns about your social media?
(Ex: time spent on devices, content viewed or shared, bullying or targeting you've experienced, sharing intimate photos, people have made you feel uncomfortable or forced to do something online, etc.)

_____

_____

_____

Substance Use

During the past 6 months how many days/week did you:

	Never	One or more days	Skip Question for now
Drink more than a few sips of any alcohol?	☐	☐	☐
Use marijuana in any form, including synthetic marijuana?	☐	☐	☐
Use anything else to get high, including vaping?	☐	☐	☐
Use any tobacco or nicotine products?	☐	☐	☐

Please answer the following questions:

	Yes	No
Have you ever ridden in a car driven by someone (including yourself) who was high or had been drinking?	☐	☐
Do you ever use alcohol or drugs to help you relax or fit in?	☐	☐
Do you ever use alcohol or drugs when you are alone?	☐	☐
Do you ever forget things you have done while using alcohol or drugs?	☐	☐
Has anyone ever told you that you should cut back on alcohol or drugs?	☐	☐

Mood Questions

How often have you been bothered by each of the following symptoms in the last TWO weeks?

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	☐	☐	☐	☐
Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐

Please describe other difficult mood and/or feelings you experience regularly:

_____

_____

Worry Questions

Over the last TWO weeks, how often have you been bothered by the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

Health Questions

Please answer the following questions

	Yes	No	Skip Question
Are you dissatisfied/frustrated by your body weight and/or shape?	☐	☐	☐
Do you feel that you have a loss of control over how much you eat?	☐	☐	☐
Do you ever do anything in order to lose weight or feel less full? *Ex: restrict, make self sick, exercise, use laxatives*	☐	☐	☐

Do you exercise regularly? If yes, what do you like to do and how often?

_____

How do you feel about your diet/nutrition?

_____

How many hours of sleep do you get each night on average? _____

Are you or have you ever been sexually active? ☐ Yes ☐ No ☐ No, but I think about it a lot ☐ Skip Question for now

How do you identify yourself? ☐ Female/her/she ☐ Male/he/him ☐ Non-binary/them/they/their

What do you enjoy doing for fun and in your free time?

_____

_____

What are your education/job goals after your high school career?

_____

_____

Name one or two adults you can trust and what their role in your life is.

_____

_____

Who do you admire/look up to?

_____

_____

What is your expectation of this appointment; with treatment plan if it is encouraged to start therapy and/or medication?

_____

_____

Do you have any questions you would like to discuss during your appointment?

_____

_____