HIGH PLAINS PSYCHOLOGICAL ASSESSMENT CENTER, LLC
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CHILD AND ADOLESCENT INTAKE FORM

GENERAL INFORMATION

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Client's (child) Name: ____ Today's Date:_____________

Date of Birth: ________ /_________ /__________ Child's age _________

Name of person completing this form: ____

Relationship to client: ____

Are you the legal guardian of the child? Yes_____ No______

If no, who is the child's legal guardian? ____

Address:____

____

Home phone:___________________________________ May I leave a message? Yes No

Mother's Cell phone:______________________________ May I leave a message? Yes No

Father's Cell phone: ______________________________ May I leave a message? Yes No

Mother's Work phone: ____________________________ May I leave a message? Yes No

Father's Work phone:_____________________________ May I leave a message? Yes No

Email: ____ May I email you? Yes No

Who referred you to High Plains? Please provide agency/professional's name and contact information:

____

May we contact the agency/person to thank them for referring you? Yes____ No ____ Please initial:___________

Do you want us to share the final report with them? Yes____ No ______ Please initial: ___________

What are the <u>main reasons</u> you're seeking an evaluation? (Please include how long you have noticed these symptoms or problems): ____

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What do you hope to gain from this evaluation?________________________________

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SYMPTOMS:

How much are each of the symptoms below a concern for your child?

	Not at all 1	A little 2	Somewhat 3	Considerably 4	Terribly 5
Academic/Learning Problems	1	2	3	4	5
Behavior Difficulties	1	2	3	4	5
Problems with Social Relationships	1	2	3	4	5
Social Withdrawal	1	2	3	4	5
Restricted Interests	1	2	3	4	5
Anxiety	1	2	3	4	5
Fear of Certain Objects/Situations	1	2	3	4	5
Repetitive Behaviors or Mental Acts	1	2	3	4	5
Avoiding Certain Things/Places	1	2	3	4	5
Panic Attacks	1	2	3	4	5
Intrusive Memories	1	2	3	4	5
Irritability	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Changes in Eating/Appetite	1	2	3	4	5
Depression	1	2	3	4	5
Low Self-Esteem	1	2	3	4	5
Self-harm/Suicidal Thoughts	1	2	3	4	5
Inappropriate Expression of Anger	1	2	3	4	5

Difficulty Meeting Expectations	1	2	3	4	5
Difficulty Problem-solving	1	2	3	4	5
Memory Problems	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Legal Problems	1	2	3	4	5
Family Conflicts	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Please describe any other symptoms your child has experienced (not listed above).

____

____

____

Has your child experienced any unusually severe stresses during the last year? Yes No

If yes, please describe:____

____

____

What do you consider to be your child's strengths?_______________________

____

What do you consider to be areas of needed growth for your child?__________

____

HEALTH & MENTAL HEALTH INFORMATION

Does your child <u>currently</u> have any medical problems? ______________________

____

____

Has your child ever <u>been treated</u> for any of the following? If so please circle and describe:
Head injury, strokes, seizures, fainting, loss of consciousness, neurologic conditions (Multiple sclerosis, Parkinson's), cancer, headaches, diabetes/kidney, allergies, chronic fatigue, high fevers, surgeries, any other conditions:

____

____

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Has your child previously seen a therapist or psychiatrist? If so, what year? Who did your child see and for what reason? About how many meetings did he/she have? Was the experience helpful or not? How so? ____

____

____

____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

____

____

____

Has your child attempted suicide? Yes ______ No ______

Has your child engaged in self-harm behaviors? Yes ______ No ______

If yes, please describe:

____

____

____

____

Please list current prescription medications with dosage (psychiatric and general health):

____

____

____

Please list any previous psychiatric medications (with dosage and dates): ___________________________

____

____

Who is your child's primary care physician? ____

Who is your child's psychiatrist (if applicable)? ____

When was your child's last complete physical exam (month/year)? _______________________________

____

To the best of your knowledge, please indicate for each substance listed below

Substance	Ever Used?	Age at 1st Use	Time Since Last Use	Approx. Use in last 30 days
Alcohol				
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				
Other Drugs				

FAMILY MENTAL HEALTH HISTORY

In the section below identify any members of your child's family and extended family who have a history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	______________________
Obsessive Compulsive Behavior	Yes	No	______________________
Depression	Yes	No	______________________
Suicide Attempts	Yes	No	______________________
Bipolar/Manic Depressive	Yes	No	______________________
Alcoholism	Yes	No	______________________
Substance Abuse	Yes	No	______________________
Domestic Violence	Yes	No	______________________
Eating Disorders	Yes	No	______________________
Obesity	Yes	No	______________________
Schizophrenia	Yes	No	______________________
Counseling or Psychotherapy	Yes	No	______________________
Psychiatric Hospitalizations	Yes	No	______________________

Adoption History

Was the child adopted? ____

If yes, what age was he/she adopted? _________ Is he/she aware of their adoption? ______________

How many home placements/homes has the child had in his/her lifetime? (Please describe in terms of type of placement, age at placement, reason for change in living arrangement, etc.) ___________

____

____

____

Does the child have contact with his/her biological mother and/or father? ___________________________

Pregnancy and Birth History

This child was the birth mother's _________ (write number) pregnancy.

List any complications during the pregnancy: ____

____

____

List any prescription medications, alcohol, nicotine or drugs taken during pregnancy: ________________

____

The child was delivered via: C-Section ____________ Vaginal Delivery _____________

Was the child considered full term? Yes __________ No ___________

How many weeks gestation age was the child when he/she was delivered? _____________________

Birth weight ________________

List any delivery complications: ____

____

How long was the child in the hospital after delivery? ____

Interventions required for the child after birth (phototherapy, oxygen, etc.): ________________________

____

Did the child's mother experience depression or anxiety in the first two years of the child's life? _______

____

____

Early Developmental Milestones

Please indicate the approximate age at which the child met the following milestones:

First single words ____________

First 2-3 word phrases _______________

Sat unassisted _______________

Crawled _______________

Walked ______________

Pretend play ______________

Toilet trained (day) _______________

Toilet trained (night) _______________

Personal History

Where was your child born? ____

How many times has your child moved? ____

List all people who currently live with the child? ____

____

____

Parents are: Married ____ Divorced _____ Separated ______ Never Married _____ Other ___________

Type of Legal Custody: Joint ____ Sole ______ Other ____

Type of Physical Custody: Joint ____ Sole ______ Other ______________________________________

*Please provide current separation agreement or cord order to very legal custody.

Do you have any pending custody matters? Yes _____ No ______ Please describe: _________________

____

Has Child Protective Services ever been involved or has there been an abuse report filed against any of the child's care takers? Yes ____ No _____

If yes, please explain (When, what, who was involved, what state, what was the finding): _____________

____

____

____

Siblings

Please list all of your child's brothers and sisters.

First name	Full, Half, Step, Adoptive	Current Age	Male/ Female	Describe your child's relationship with this individual in a few words

Educational History

Does your child receive any special accommodations in school (Individualized Education Program, 504 Plan, informal supports)?

____

____

Has your child ever repeated a grade? ____

What have teachers and other school professionals told you about your child? __________________

____

____

What subject(s) does your child excel in? ____

____

What subject(s)s does your child struggle with? ____

____

Social Relationships/Interests/Activities

Please describe your child's social relationships. _______________________________________

____

____

____

What are some of your child's interests & activities? ____________________________________

____

____

Is there any other information you would like us to know about your child?___________________

____

____

____

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____