



Saint Alphonsus

Behavioral Health Services

1055 N. Curtis Rd. • Boise, ID 83706 • (208) 367-2121

CHILD/ADOLESCENT INTAKE FORM

Today's date: _____

Patient Information:

Individual Name: _____ Date of Birth: _____ Age: _____
(first) (last)

Gender M/F Ethnicity (optional): _____

Name of Person completing this form: _____

Relationship to individual: _____ Years known: _____

Residence of child: (circle) Biological parents Adoptive parents Foster parents PCS Home
Other: _____

Patient Contacts:

Mother's name: _____ Age: _____
(first) (last)

Father's name: _____ Age: _____
(first) (last)

Marital Status of Parents: (circle) Married Divorced Separated Widowed

Mother's Address: _____
(street) (city) (state) (zip code)

Father's Address: _____
(street) (city) (state) (zip code)

Contact phone numbers:

Name/Relationship: _____ Number: _____

Who has legal/physical custody? _____ Type: _____
(please provide legal documentation)

Support Services:

Does this individual receive services from Health and Welfare? Yes No

Case Worker (name): _____ Phone: _____

Services Received: _____ Region: _____

Referral Information:

Who referred you to this clinic?

(name) (phone)

(address)

Presenting Problem:

What concerns you most about this individual?

When did you first notice this problem?

How has this problem affected his/her function?

At home: _____

At school/work: _____

Community: _____

Do you have other concerns you want addressed?

What are your goals/expectations for treatment? _____

Have you recently worried that your child has (please circle items relevant to your child):

- Yes No DEPRESSION (sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in things, etc.)
- Yes No MOOD SWINGS (energetic, little sleep, pleasure seeking, racing thoughts, too talkative, inappropriate sexual behaviors, grandiose, etc.)
- Yes No ANXIETY (worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences, etc.)
- Yes No BEHAVIORAL PROBLEM (fights, anger, arguing, truancy, destruction of property, fire setting, etc.)
- Yes No ATTENTION/HYPERACTIVITY PROBLEM (difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks)
- Yes No ABNORMAL EATING BEHAVIORS (too much, too little, fear of weight gain, distorted body image, over exercising, etc.)

- Yes No SOCIAL ANXIETY (shy and/or afraid to be around others)
- Yes No REMEMBERING PAST TRAUMAS (frequent nightmares, intrusive and/or recurrent memories, etc.)
- Yes No AUTISM (social and language impairments, rigidity)
- Yes No PSYCHOSIS (hearing voices, seeing things, paranoia, delusions)
- Yes No DISSOCIATION (feeling outside your body or things are not real, etc.)
- Yes No Has your child ever harmed themselves intentionally? Attempted suicide? Harmed others? _____

Sleep Patterns:

Total hours of sleep per night: _____ Usual Schedule: _____ to _____

Does the individual take naps during the day? Yes No

If Yes, how many hours in a typical day? _____

Concerns:	Current Problem	Change within last 6 months
Difficulty falling asleep:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent awakening:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Snoring:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Restlessness/Movements:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Early morning awakening:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nightmares:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Not rested:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If yes to any of the concerns listed above, please describe: _____

Past Psychiatric History:

Please list any previous psychiatric hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs)

<i>Diagnosis</i>	<i>Length of Stay</i>	<i>Treatment</i>	<i>Response</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any current or prior outpatient psychiatrists and therapists your child has seen?

<i>Name</i>	<i>Title</i>	<i>Location</i>	<i>How Long?</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list this individual's current psychiatric medications. (You may refer to the list of medications on the next page)

Name *Dosage* *Duration* *Response*

Please list this individual's current non-psychiatric medications.

Name *Dosage* *Duration* *Response*

Please list all the psychiatric medications that have been tried in the past (if greater than 4 medications please attach separate list). (You may refer to the list of medications on the next page).

Name *Highest Dosage* *Duration* *Response* *Reason for Stopping*

Example: Dexedrine, 5 mg twice daily, 09/98-11/98, good, poor sleep

Drug and Alcohol History:

Substance	Date of Last Use	Problems Related to Use	Treatment Required
Benzodiazepines (Valium, Xanax, Ativan)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marijuana		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cocaine		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Designer Drugs (Club Drugs: G, X)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hallucinogens (LSD, Mushrooms)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inhalants (Gasoline, Glue, Aerosol)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Methamphetamines (Speed, Ice, Ritalin)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Opiates/Methadone (Vicodin, OxyContin, Heroin)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
OTC – <i>Over the counter</i> (Benadryl, Nyquil, Dramamine)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tobacco none Amount per day:

Is there anything else we should know about any drug history?

<p>Adderall® (dextroamphetamine + amphetamine)</p> <p>Abilify® (aripiprazole)</p> <p>Adipex-P® (phentermine)</p> <p>Ambien® (zolpidem)</p> <p>amitriptyline (Elavil®)</p> <p>Amoxapine</p> <p>Antabuse® (disulfiram)</p> <p>Anafranil® (clomipramine)</p> <p>Aricept® (donepezil)</p> <p>Ativan® (lorazepam)</p> <p>Aventyl® (nortriptyline)</p> <p>Benadryl® (diphenhydramine)</p> <p>Buspar® (buspirone)</p> <p>Carbatrol® (carbamazepine)</p> <p>Catapres® (clonidine)</p> <p>Celexa® (citalopram)</p> <p>Chloral hydrate</p> <p>Clozaril® (clozapine)</p> <p>Cogentin® (benztropine)</p> <p>Concerta® (methylphenidate)</p> <p>Cymbalta® (duloxetine)</p> <p>Cylert® (pemoline)</p> <p>Dalmane® (flurazepam)</p> <p>Depakote®/Depakene® (valproic acid/valproate)</p> <p>Dexedrine® (dextroamphetamine)</p> <p>Didrex® (benzphetamine)</p> <p>Dilantin® (phenytoin)</p> <p>Dolophine®/Methadose® (methadone)</p> <p>Effexor XR® (venlafaxine)</p> <p>Elavil® (amitriptyline)</p> <p>Ephedra®</p> <p>Eskalith® (lithium)</p> <p>Evening primrose oil</p> <p>Focalin® (dexmethylphenidate)</p> <p>Gabitril® (tiagabine)</p> <p>Geodon® (ziprasidone)</p> <p>Ginkgo biloba</p> <p>Ginseng</p>	<p>Halcion® (triazolam)</p> <p>Haldol® (haloperidol)</p> <p>imipramine (Tofranil®)</p> <p>Inderal® (propranolol)</p> <p>Keppra® (levetiracetam)</p> <p>Klonopin® (clonazepam)</p> <p>Lamictal® (lamotrigine)</p> <p>Lexapro® (escitalopram)</p> <p>Librium® (chlordiazepoxide)</p> <p>Lithobid® (lithium)</p> <p>Loxitane® (loxapine)</p> <p>Luminal® (phenobarbital)</p> <p>Luvox® (fluvoxamine)</p> <p>Melatonin</p> <p>Mellaril® (thioridazine)</p> <p>Marplan® (isocarboxazid)</p> <p>Meridia® (sibutramine)</p> <p>Metadate® (methylphenidate)</p> <p>Methylin® (methylphenidate)</p> <p>Moban® (molindone)</p> <p>Mysoline® (primidone)</p> <p>Nardil® (phenelzine)</p> <p>Navane® (thiothixene)</p> <p>Neurontin® (gabapentin)</p> <p>Norpramin® (desipramine)</p> <p>nortriptyline (Pamelor®)</p> <p>Omega fatty acids</p> <p>Orap® (pimozide)</p> <p>Pamelor® (nortriptyline)</p> <p>Parnate® (tranylcypromine)</p> <p>Paxil® (paroxetine)</p> <p>Periactin® (cyproheptadine)</p> <p>Prolixin® (fluphenazine)</p> <p>propranolol (Inderal®)</p> <p>ProSom® (estazolam)</p> <p>protriptyline (Vivactil®)</p> <p>Provigil® (modafinil)</p> <p>Prozac® (fluoxetine)</p> <p>Remeron® (mirtazapine)</p>	<p>Restoril® (temazepam)</p> <p>ReVia® (naltrexone)</p> <p>Risperdal® (risperidone)</p> <p>Ritalin® (methylphenidate)</p> <p>SAM-e</p> <p>Saint john's wort</p> <p>Sarafem® (fluoxetine)</p> <p>Serax® (oxazepam)</p> <p>Seroquel® (quetiapine)</p> <p>Serzone® (nefazodone)</p> <p>Sinequan® (doxepin)</p> <p>Sonata® (zaleplon)</p> <p>Stelazine® (trifluoperazine)</p> <p>Strattera® (atomoxetine)</p> <p>Subutex® (buprenorphine)</p> <p>Suboxone® (buprenorphine + naloxone)</p> <p>Symbiax® (olanzapine + fluoxetine)</p> <p>Tegretol® (carbamazepine)</p> <p>Tenex® (guanfacine)</p> <p>Tenuate® (diethylpropion)</p> <p>Thorazine® (chlorpromazine)</p> <p>Tofranil® (imipramine)</p> <p>Topamax® (topiramate)</p> <p>Tranxene® (clorazepate)</p> <p>trazodone (Desyrel®)</p> <p>Trilafon® (perphenazine)</p> <p>Trileptal® (oxcarbazepine)</p> <p>Valerian</p> <p>Valium® (diazepam)</p> <p>Vistaril® (hydroxyzine)</p> <p>Wellbutrin® (bupropion)</p> <p>Xanax® (alprazolam)</p> <p>Zarontin® (ethosuximide)</p> <p>Zoloft® (sertraline)</p> <p>Zonegran® (zonisamide)</p> <p>Zyprexa® (olanzapine)</p> <p>Zydis® (olanzapine)</p>
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Family History:

Consider this individual's immediate family and all of their relatives on both sides (parents, brothers, sisters, aunts, uncles, grandparents, and 1st cousins)

Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Uncle") and their treatment history (if applicable). Maternal is mother's side of the family and Paternal is father's side of the family.

- _____ Depression _____
- _____ Anxiety _____
- _____ ADHD _____
- _____ Bipolar (manic depressive) _____
- _____ Schizophrenia _____
- _____ Alcohol/Drug Problems _____
- _____ Learning Disabilities _____
- _____ Autism/Asperger/Pervasive Developmental Disorder _____
- _____ Mental Retardation _____
- _____ "Nervous Breakdown" _____
- _____ Psychiatric Hospitalizations _____
- _____ Suicide (or attempts) _____
- _____ Panic Disorder _____
- _____ PTSD (Post Traumatic Stress Disorder) _____
- _____ OCD (Obsessive Compulsive Disorder) _____
- _____ Seizures _____
- _____ Migraines _____
- _____ Heart or lung problems _____
- _____ Thyroid _____
- _____ Immunological disorders (lupus, scleroderma, inflammatory bowel disease) _____
- _____ Cancer _____
- _____ Other _____

Developmental History:

Did your child achieve the following milestones early (E), average (A), or late (L) compared with others his/her age (please explain if late):

- _____ Language (age at first using words, sentences, etc...)?

- _____ Fine motor skills (building towers with cubes, drawing circle)

- _____ Gross motor skills (rolling over, standing, walking)?

- _____ Toilet training?

Has your child experienced any regression of these? Yes No If yes, explain: _____

Pregnancy and Birth History:

How old was this child's biological parents when he/she was conceived? _____

Was this the biological mother's first pregnancy? Yes No

If no, how many times was she pregnant before this pregnancy? _____

Did the biological mother experience any miscarriages before or after this pregnancy? Yes No

If yes, how many? _____ During what trimester? _____

When was prenatal care first received (in weeks): _____

How much weight did the biological mother gain during this pregnancy?: _____

Baby's birth weight and length: _____

Length of pregnancy (in weeks): _____

Did the mother have any ultrasounds or amniocentesis? Yes No If yes, please describe the reason for these and the results: _____

Please indicate whether any of the following events/problems occurred during this pregnancy. Please include the trimester in which the event occurred, as well as any other important details.

	Yes / No	# of months into pregnancy	Additional details
Infections/Colds	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Fevers	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hospitalizations	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Vaginal Bleeding, Spotting	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Problems with Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pregnancy Induced Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No		
High Blood Pressure, Excessive Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Rh or Blood Incompatibilities	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Trauma (Emotional Stress and/or Physical Injury)	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Did you take any medications (prescription and over the counter) during this pregnancy? (If yes, please complete the following table.)

Medication	Month(s) taken (1-9)	Dose	Reason for taking

Did you consume alcohol during this pregnancy? Yes No
 If yes, how much and how often? _____

Did you smoke or use tobacco products during this pregnancy? Yes No
 If yes, please describe how much and how often? _____

Did you use any drugs during this pregnancy? Yes No
 If yes, please name drug(s), how much and frequency of use: _____

Labor Information:

Type of delivery (c-section, vaginal): _____

Were forceps used? _____

Were there any problems with the baby's health right before or immediately after delivery? Yes No

If yes, please describe: _____

Were the mother and/or baby separated after birth for more than 24 hours at a time? Yes No

If yes, please explain: _____

Past Medical History:

Primary Care Provider: _____ Years Involvement: _____

Phone: _____

Address: _____

Approximate Date of Last Visit: _____

Number of Visits in Last Year: _____

Other Provider(s): _____

Specialty: _____

Name: _____ Phone: _____

Address: _____

Other Provider(s): _____

Specialty: _____

Name: _____ Phone: _____

Address: _____

Allergies (drug, food, seasonal, environmental etc.)? Yes No If yes, please name and describe your child's reaction: _____

Has your child ever experienced a head injury, loss of consciousness, or seizure? Yes No
If yes, please describe: _____

Does your child have any chronic medical problems? Yes No If yes, please describe: _____

Does your child have a history of any serious injuries or medical hospitalizations? Yes No
If yes, please describe: _____

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? Yes No
If yes, please describe: _____

Have you recently worried that your child may have problems with:

- | | | |
|--|---|----------------------------------|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Constipation/Diarrhea | Age of first menses _____ |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Frequent infections | Regular or Irregular cycle _____ |
| <input type="checkbox"/> Kidneys/Bladder | <input type="checkbox"/> Endocrine (i.e., diabetes; thyroid dysregulation; excessive hair growth) | |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Immunizations up to date | |

Has your child ever had an EEG, MRI, CT SCAN, etc? Yes No _____

If yes, why was it done and were the results normal? _____

If yes, where were the tests performed and who ordered them? _____

Social History:

Is your child your biological child? Yes No

If no, at what age was he/she adopted? _____

Is there any contact with their biological parent(s)? _____

Where was your child born and raised? _____

Has your child moved a number or times? Yes No _____

If yes, please list their age at time of move and location: _____

Parents: (Including Step-Mother and Step-Father, if applicable)

Name *Education* *Occupation* *Hrs/Wk* *Relationship with Child (quality)*

Please list the other children in the family and other household members who may also be living in your home:

Name *Age* *Lives at Home?* *Relation to Child* *Relationship with Child*

Abuse History:

Has your child ever been the victim of abuse or neglect? Yes No

If yes, what was the nature of the abuse? (Please circle all that apply.)

Physical Emotional Neglect
Accidents Disasters Sexual
Witnessing violence Other: _____

Are you struggling with your marital relationship or parenting? Yes No

If yes, please describe: _____

Has your child ever been involved with the following and if yes, please explain:

Yes No Child Protective Services _____
 Yes No Childrens Mental Health _____
 Yes No Probation/Juvenile Probation/Detention _____
 Yes No Boys and Girls Club _____
 Yes No Youth Services _____
 Yes No Head Start _____
 Yes No Early Intervention Services (ages 0-3) _____

School:

Where does your child attend school? _____

In what grade level is he/she? _____

What are his/her typical grades? _____

What are your child's academic strengths? _____

Academic weaknesses? _____

Has there been a change in your child's performance at school? Yes No If yes, please describe: _____

Has your child received IQ or Academic testing? Yes No If yes, what were the results? _____

Does or has your child participated in any of the following?

Yes No Resource (for which classes/how many hours?) _____

Yes No Accelerated or Honors programs, explain: _____

Yes No 504 Plan, explain: _____

Yes No Individual Education Plan (IEP), explain: _____

Yes No Virtual Academy, explain: _____

Has your child had problems with any of the following?

Yes No Truancy, explain: _____

Yes No Fights, explain: _____

Yes No Absenteeism, explain: _____

Yes No Detention, explain: _____

Yes No Suspension, explain: _____

Yes No School refusal, explain: _____

What are your child's favorite activities? _____

Peers:

Does your child have quality relationships with other children? Yes No If no, please explain: _____

Culture:

Do you have a religious preference in the household? Yes No If yes, what is that preference? _____

Has your child experienced any problems related to race, religion, or culture? Yes No If yes, please explain: _____

Mental Status Exam:

Clinical Interview Notes:

Three wishes

Wants to be when grow up

Happiest time

Saddest time

Scariest time

INITIAL FORMULATION:

INITIAL DIAGNOSES:

AXIS I:

AXIS II:

AXIS III:

AXIS IV:

AXIS V:

INITIAL TREATMENT PLAN:

1. MEDICATIONS:
2. PSYCHOTHERAPY:
3. MEDICAL:
4. ACADEMIC:
5. FOLLOW UP:
6. CRISIS (IF APPLICABLE):