Center for Family Development

Child/Teen Intake Questionnaire

Parents-In order for me to be able to fully evaluate your child or teenager, please fill out the following intake form and questionnaires to the best of your ability. I realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your child or teenager's medical chart it is ok to refrain from putting it on this form. If a question does not apply to your child mark it N/A. Thank you!

PATIENT IDENTIFICATION

Patient Name _____ Nickname_____ First Appointment Date: _____

Birth Date _____ Age _____ Sex _____ Race _____ SS# _____

School _____ Grade _____ Special Ed: Yes No Certification Type: _____

Biological Mother _____Date of Birth: _____Religion _____Race _____

Mother's Employer: _____ Is the child covered under that insurance? Yes No

Biological Father _____Date of Birth: _____Religion:_____Race:_____

Father's Employer: _____ Is the child covered under that insurance? Yes No

The legal address of the child, and information about who lives in that home:

Address: _____

City _____ State _____ Zip _____

Please only list the numbers you want us to call you where I can feel free to leave a message identifying ourselves as from the Center for Family Development.

Home Phone: _____ Any Other important contact number:_____

Mother's Work: _____ Mother's Cell: _____ Mother's email: _____

Father's Work: _____ Father's Cell: _____ Father's email: _____

Minor's Cell: _____ Minor's email: _____

List all the people the child is currently living with at the home listed above: (use the back of this sheet if necessary)

Person Date of Birth Relationship to patient Comment

_____

_____

_____

Have the biological parents been divorced? Yes No Date of divorce: _____ Age of child at that time:___

Do both parents have legal custody? Yes No Details: _____

Do the natural parents share joint physical custody or does one have sole physical custody? _____

What percentage of uninsured medical expenses does the judgment of divorce say that you are responsible for? ____

Has the child been legally adopted? Yes No by whom? _____

Does anyone else have legal or physical custody? Yes No Details: _____

The address of the other parent and information about who lives in that home:

Address: _____

City _____ State _____ Zip _____

Who referred you to us? _____

Referral Address _____

Referral City and Zip _____

Do we have permission to release information to the referring professional when it is appropriate? Yes No

MAIN PURPOSE OF THE CONSULTATION (please give a brief summary of the main problems)

_____

_____

What lead you to seek evaluation and treatment at this time?

_____

_____

What do you want us to do for your child, yourself or your family?

_____

_____

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY (Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

_____

Current medical problems/medications: _____

Past medical problems/medications" _____

Other doctors/clinics seen regularly: _____

Any history of head trauma? (describe): _____

Ever any seizures or seizure like activity? _____

Any period of spaciness or confusion? _____

Prior hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc.: _____

Allergies/drug intolerances (describe): _____

Child's present height _____ Present weight _____

Do you have a carbon monoxide detector in your home: Yes No

Does your child have silver amalgam dental fillings? Yes No

Current Stresses (please list current factors that are a source of stress in the family _____

_____

Family Story

Family Structure-describe the emotional tone in the current household with the child, and the relationship between the parents and other family members:

_____

_____

Current Marital Situation/Satisfaction of Parents:

_____

_____

Family History (include marriages, separations, divorces, deaths, traumatic events, losses, etc.)

_____

_____

Biological Mother's History: Her age when child born _____

Does mother work outside the home? Yes No Describe Job and hours:

_____

_____

School: highest grade completed: _____

Learning problems (specify): _____

Behavior problems (specify): _____

Marriages: _____

Medical Problems: _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____ _

Has mother ever sought psychiatric treatment? Yes No

If yes, for what purpose? _____

Mother's alcohol/drug use history _____

Have any of mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, bipolar disorder, anxiety, suicide attempt, psychiatric hospitalizations? (specify)

_____

_____

_____

Biological Father's History: His Age when child born _____ does father work outside the home? Yes No

Describe job and hours: _____

_____

School: highest grade completed _____

Learning problems (specify): _____

Behavior problems (specify): _____

Marriages _____

Medical problems _____

Childhood atmosphere (family position, abuse, illnesses, etc.) _____

_____

Has father ever sought psychiatric treatment? Yes No

If yes, for what purpose? _____

Father's alcohol/drug use history _____

Have any of father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, bipolar disorder, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

_____

_____

(If applicable)

Step or Adopted Mother's history (indicate which): Date of birth: _____ outside work _____

School: highest grade completed _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse. illnesses. etc) _____

Has step-mother ever sought psychiatric treatment? Yes __ No_ _

If yes, for what purpose? _____

Step or adopted mother's alcohol/drug use history _____

Step or Adopted Father's History (Indicate which):

Date of Birth: _____

His Age when child born _____

Does stepfather work outside the home? _____

School: highest grade completed: _____

Learning problems (specify) _____

Behavior problems (specify) _____

Marriages _____

Medical Problems_____

Childhood atmosphere (family position. abuse, illnesses. etc) _____

_____

Has step or adopted father ever sought psychiatric treatment? Yes No If yes, for what purpose?

_____

Step or adopted father's alcohol/drug use history _____

Siblings: (names, ages, problems, strengths, relationship to patient)

_____

_____

_____

_____

_____

CHILD'S DEVELOPMENTAL HISTORY

Significant Prenatal events: _____

Parents attitude toward pregnancy _____

Conception--ease _____ planned _____ unplanned _____

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol, drug use, etc

_____

How active was the baby when you carried it: Very active: _____ Average _____ Minimally _____

Birth and Postnatal period:

Birth weight _____ Length _____ Labor duration _____ Delivery: vaginal ___ C section ____

Problems:_____

APGAR scores (if known) _____ _____ Any jaundice? Yes __ No __ Time in hospital _____

Complications? _____

Mother's health after delivery: _____

Post delivery blues? _____ if yes, how long? _____

Who was the primary caretaker for child, first year _____

thereafter _____

Feeding history: breast vs bottle _____ age weaned _____Food allergies _____

Current eating problems _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

Separation problems from mother and/or father: age, duration, reaction to _____

Toilet training: age reached bowel control: day _____ night _____ bladder control: day _____ night _____

methods used _____ ease _____ current function _____

Sexual development: gender identity _____

any problems _____

Physical/Sexual abuse: _____

_____

Motor development: (please write in age, parentheses are the approximate normal limits)

rolls over (3-5m) _____ sit without support (5-7m) _____ crawls (5-8) _____

walks well (11-16m) _____ runs well (2y) _____ rides tricycle (3y) _____

throws ball overhand (4y) _____ current level of activity _____

fine and gross motor coordination _____compared to peers _____

Language development: (please write in age, parentheses are the approximate normal limits)

several words besides dada, mama (l y) _____ name several objects-ball, cup (15m) _____

3 words together--subject, verb, object (24m) _____ vocabulary _____ articulation _____

comprehension _____ compared to peers _____

any current problems _____

Social development: (please write in age, parentheses are the approximate normal limits)

smile (2m) _____ shy with strangers (6-lOm) _____ separates from mother easily (2-3y) _____ _____

cooperative play with others (4y) _____

quality of attachment to mother _____ quality of attachment to father _____

relationships to family members _____

early peer interactions _____

current peer interactions _____

special interests/hobbies _____

Behavioral/Discipline: compliance vs non-compliance _____ _____

lying/stealing _____rule breaking _____ methods of discipline _____

other problems _____

Emotional development: early temperament _____

current personality _____ _____

mood _____ fears/phobias _____

habits _____ _____ _

special objects (blankets, dolls, etc.) _____ ability to express feelings _____

Drug/Alcohol History: _____

School History: current grade _____ school contact _____

number of schools attended _____ average grades _____

homework problems _____

specific learning disabilities _____

strengths _____

what have teachers said about the child: _____

_____

Please bring school report cards and any state, national or special testing that has been performed.

Sleep behavior: Is it hard for your child to go to bed? Yes No Explain: _____

How long does it take them to fall asleep? _____

Once they fall asleep do they stay asleep? Yes No

Do they snore? Yes No

How many hours of sleep do they usually get? _____

Do they have sleepwalking, nightmares, night terrors, recurrent dreams, restless legs, talking in their sleep:

_____

_____

Overall Strengths - as viewed by parents _____

_____

Overall Strengths -- as viewed by the child/teen _____

_____

Is there anything else you want me to know? _____

_____

Primary Insurance Information:

Insurance Company name: _____

Policy Number or Contract #: _____ Group #: _____

Social Security number of Policyholder: _____

Employer Name: _____ Name of Policyholder: _____
Birth Date of Policyholder: _____ Address of policyholder: _____

City: _____ State: _____ Zip: _____ Phone: _____

Secondary Insurance Information:

Insurance Company name: _____

Policy Number or Contract #: _____ Group #: _____

Social Security number of Policyholder: _____

Employer Name: _____ Name of Policyholder: _____

Birth Date of Policyholder: _____ Address of policyholder: _____

City: _____ State: _____ Zip: _____ Phone: _____

I understand as the primary responsible party, I will pay for all portions of charges that my insurance Company does not cover. I authorize the Center for Family Development to electronically transmit the claim to the insurance company, send any necessary documentation and discuss this case including diagnosis and other information from the clinical record with the insurance companies listed. I authorize my insurance company to send benefits directly to the Center for Family Development.

In case of canceled appointments, I agree to provide **24 hours** notice to the Center for Family Development or be responsible for a $30.00 missed appointment fee.

Signature of Responsible Party: _____ Date: _____

Amen Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other _____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

Other	Self		
____	___	1.	Failing to give close attention to details or making careless mistakes
____	___	2.	Having trouble sustaining attention in routine situations (e.g., homework, chores, paperwork)
____	___	3.	Having trouble listening
____	___	4.	Failing to finish things
____	___	5.	Having poor organization for time or space (such as a backpack, room, desk, paperwork)
____	___	6.	Avoiding, disliking, or being reluctant to engage in tasks that require sustained mental effort
____	___	7.	Losing things
____	___	8.	Being easily distracted
____	___	9.	Being forgetful
____	___	10.	Having poor planning skills
____	___	11.	Lacking clear goals or forward thinking
____	___	12.	Having difficulty expressing feelings
____	___	13.	Having difficulty expressing empathy for others
____	___	14.	Experiencing excessive daydreaming
____	___	15.	Feeling bored
____	___	16.	Feeling apathetic or unmotivated
____	___	17.	Feeling tired, sluggish or slow moving
____	___	18.	Feeling spacey or "in a fog"
____	___	19.	Feeling fidgety, restless or trouble sitting still
____	___	20.	Having difficulty remaining seated in situations where remaining seated is expected
____	___	21.	Running about or climbing excessively in situations in which it is inappropriate
____	___	22.	Having difficulty playing quietly
____	___	23.	Being always "on the go" or acting as if "driven by a motor"
____	___	24.	Talking excessively
____	___	25.	Blurting out answers before questions have been completed
____	___	26.	Having difficulty waiting for turn
____	___	27.	Interrupting or intruding on others (e.g., butting into conversations or games)
____	___	28.	Behaving impulsively (saying or doing things without thinking first)
____	___	29.	Worrying excessively or senselessly
____	___	30.	Getting upset when things do not go your way
____	___	31.	Getting upset when things are out of place
____	___	32.	Tending to be oppositional or argumentative
____	___	33.	Tending to have repetitive negative thoughts
____	___	34.	Tending toward compulsive behaviors (i.e., things you feel you *must* do)
____	___	35.	Intensely disliking change
____	___	36.	Tending to hold grudges
____	___	37.	Having trouble shifting attention from subject to subject
____	___	38.	Having trouble shifting behavior from task to task
____	___	39.	Having difficulties seeing options in situations
____	___	40.	Tending to hold on to own opinion and not listen to others
____	___	41.	Tending to get locked into a course of action, whether or not it is good
____	___	42.	Needing to have things done a certain way or else becoming very upset
____	___	43.	Others complaining that you worry too much
____	___	44.	Tending to say no without first thinking about the question
____	___	45.	Tending to predict fear
____	___	46.	Experiencing frequent feelings of sadness
____	___	47.	Having feelings of moodiness
____	___	48.	Having feelings of negativity

____ ___49. Having low energy
____ ___50. Being irritable
____ ___51. Having a decreased interest in other people
____ ___52. Having a decreased interest in things that are usually fun or pleasurable
____ ___53. Having feelings of hopelessness about the future
____ ___54. Having feelings of helplessness or powerlessness
____ ___55. Feeling dissatisfied or bored
____ ___56. Feeling excessive guilt
____ ___57. Having suicidal feelings
____ ___58. Having crying spells
____ ___59. Having lowered interest in things that are usually considered fun
____ ___60. Experiencing sleep changes (too much or too little)
____ ___61. Experiencing appetite changes (too much or too little)
____ ___62. Having chronic low self-esteem
____ ___63. Having a negative sensitivity to smells/odors
____ ___64. Frequently feeling nervous or anxious
____ ___65. Experiencing panic attacks
____ ___66. Symptoms of heightened muscle tension (such as headaches, sore muscles, hand tremors, etc.)
____ ___67. Experiencing periods of a pounding heart, a rapid heart rate, or chest pain
____ ___68. Experiencing periods of troubled breathing or feeling smothered
____ ___69. Experiencing periods of dizziness, faintness, or feeling unsteady on your feet
____ ___70. Feeling nausea or having an upset stomach
____ ___71. Experiencing periods of sweating, hot flashes, or cold flashes
____ ___72. Tending to predict the worst
____ ___73. Having a fear of dying or doing something crazy
____ ___74. Avoiding places for fear of having an anxiety attack
____ ___75. Avoiding conflict
____ ___76. Excessively fearing being judged or scrutinized by others
____ ___77. Having persistent phobias
____ ___78. Having low motivation
____ ___79. Having excessive motivation
____ ___80. Experiencing tics (either motor or vocal)
____ ___81. Having poor handwriting
____ ___82. Being quick to startle
____ ___83. Having a tendency to freeze in anxiety-provoking situations
____ ___84. Lacking confidence in own abilities
____ ___85. Feeling shy or timid
____ ___86. Being easily embarrassed
____ ___87. Being sensitive to criticism
____ ___88. Biting fingernails or picking at skin
____ ___89. Having a short fuse or experiencing periods of extreme irritability
____ ___90. Having periods of rage with little provocation
____ ___91. Often misinterpreting comments as negative when they are not
____ ___92. Finding that own irritability tends to build, then explodes, then recedes, often being tired after a rage
____ ___93. Having periods of spaciness and/or confusion
____ ___94. Experiencing periods of panic and/or fear for no specific reason
____ ___95. Experiencing visual and/or auditory changes, such as seeing shadows or hearing muffled sounds
____ ___96. Having frequent periods of *deja vu* (that is, feelings of being somewhere you have never been)
____ ___97. Being sensitive or mildly paranoid
____ ___98. Experiencing headaches or abdominal pain of uncertain origin
____ ___99. Having a history of a head injury or family history of violence or explosiveness
____ ___100. Having dark thoughts, ones that may involve suicidal or homicidal thoughts
____ ___101. Experiencing periods of forgetfulness or memory problems

Medical Review of Systems

Please place a check mark in the boxes that apply. Explain any problem areas.

General

- ❑ Being overweight
- ❑ Recent weight gain or weight loss
- ❑ Poor appetite
- ❑ Increased appetite
- ❑ Abnormal sensitivity to cold
- ❑ Cold sweats during the day
- ❑ Tired or worn out
- ❑ Hot or cold spells
- ❑ Abnormal sensitivity to heat
- ❑ Excessive sleeping
- ❑ Difficulty sleeping
- ❑ Lowered resistance to infection
- ❑ Flu-like or vague sick feeling
- ❑ Sweating excessively at night
- ❑ Urinating excessively
- ❑ Excessive daytime sweating
- ❑ Excessive thirst
- ❑ Other_____

Neurological

- ❑ Pacing due to muscle restlessness
- ❑ Forgotten periods of time
- ❑ Dizziness
- ❑ Drowsiness
- ❑ Muscle spasms or tremors
- ❑ Impaired ability to remember
- ❑ "Tics"
- ❑ Numbness
- ❑ Convulsions / fits
- ❑ Slurred speech
- ❑ Speech problem (other)
- ❑ Weakness in muscles
- ❑ Other_____

Respiratory

- ❑ Asthma, wheezing
- ❑ Cough
- ❑ Coughing up blood or sputum
- ❑ Shortness of breath
- ❑ Rapid breathing
- ❑ Repeated nose or chest colds
- ❑ Other_____

Chest and Cardiovascular

- ❑ Ankle swelling
- ❑ Rapid / irregular pulse
- ❑ Breast tenderness
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Other_____

Head, Eye, Ear, Nose, & Throat

- ❑ Facial pain
- ❑ Headache
- ❑ Head injury
- ❑ Neck pain or stiffness
- ❑ Frequent sore throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Overly sensitive to light
- ❑ See spots or shadows
- ❑ Hearing loss in both ears
- ❑ Ear ringing
- ❑ Disturbances in smell
- ❑ Runny nose
- ❑ Dry mouth
- ❑ Sore tongue
- ❑ Other_____

Gastrointestinal and Hepatic

- ❑ Trouble swallowing
- ❑ Nausea or vomiting (throwing up)
- ❑ Abdominal (stomach / belly) pain
- ❑ Anal itching
- ❑ Painful bowel movements
- ❑ Infrequent bowel movements
- ❑ Liquid bowel movements
- ❑ Loss of bowel control
- ❑ Frequent belching or gas
- ❑ Vomiting blood
- ❑ Rectal bleeding (red or black blood)
- ❑ Jaundice (yellowing of skin)
- ❑ Other_____

Musculoskeletal

- ❑ Back pain or stiffness
- ❑ Bone pain
- ❑ Joint pain or stiffness
- ❑ Leg pain
- ❑ Muscle cramps or pain
- ❑ Other_____

Skin, Hair

- ❑ Dry hair or skin
- ❑ Itchy skin or scalp
- ❑ Easy bruising
- ❑ Hair loss
- ❑ Increased perspiration
- ❑ Sun sensitivity
- ❑ Other _____

Genitourinary

- ❑ Itchy privates or genitals
- ❑ Painful urination
- ❑ Excessive urination
- ❑ Difficulty in starting urine
- ❑ Accidental wetting of self
- ❑ Pus or blood in urine
- ❑ Decreased sexual desire
- ❑ Other_____

Females

- ❑ No menses
- ❑ Menstrual irregularity
- ❑ Painful or heavy periods
- ❑ Premenstrual moodiness, irritability, anger, tension, bloating, breast tenderness, cramps, headache
- ❑ Painful menstrual periods
- ❑ Painful intercourse or sex
- ❑ Sterility infertility
- ❑ Abnormal vaginal discharge

Other_____

Males

- ❑ Impotence (weak male erection)
- ❑ Inability to ejaculate or orgasm
- ❑ Scrotal pain
- ❑ Abnormal penis discharge

Other_____

Explanation

_____
_____
_____
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