

**Naval Medical Center Portsmouth
 Directorate of Mental Health
 Child & Adolescent Psychiatry Intake Form
 620 John Paul Jones Circle, Portsmouth, VA 23708
 Phone (757) 953-5269
 Fax (757) 953-6907**

Dear Parent/Guardian, the information you provide by completing this form will help your provider in identifying your child's needs. Please use the back of these forms if more room is needed.

Child's Name: _____ Birth Date: _____ Age: _____

Child's Address: _____

This form was completed by: _____ Date: _____

Sponsor's Social Security #: _____ Rank: _____ Branch of Service _____

Sponsor's Command _____ Command's phone number _____

Who has legal custody of this patient? (ie who can legally make medical decisions about the child's care)

Who referred you to the clinic? _____

I. FAMILY DEMOGRAPHICS

FATHER or MALE CARETAKER'S INFORMATION

Name: _____ Age: _____ Occupation: _____

Living in home? Yes No If not, address _____

Relationship: Biological Father Adoptive Father Step-Father Other

Marital status: _____ Date Married: _____

(Voluntary) Cultural background: _____ Religion: _____

Telephone (home) _____ (work) _____ (cell) _____

Email _____

MOTHER or FEMALE CARETAKER'S INFORMATION

Name: _____ Age: _____ Occupation: _____

Living in home? Yes No If not, address _____

Relationship: Biological Mother Adoptive Mother Step-Mother Other

Marital status: _____ Date Married: _____

(Voluntary) Cultural background: _____ Religion: _____

Telephone (home) _____ (work) _____ (cell) _____

Email _____

II.**MAIN CONCERNS / REASON FOR REFERRAL**

A. Please list the primary concerns you have about your child: _____

B. How long have you had these concerns? _____

C. What are your goals of treatment for your child? _____

D. Does your child have problems with activities of daily living (dressing, feeding, grooming, bathing)? _____

E. Please indicate if child has exhibited any of the following behaviors:

	Past Concerns	Present Concerns
1. Has trouble hearing	<input type="checkbox"/>	<input type="checkbox"/>
2. Is overly sensitive to sounds	<input type="checkbox"/>	<input type="checkbox"/>
3. Has visual problems	<input type="checkbox"/>	<input type="checkbox"/>
4. Tilts his/her head to look at items	<input type="checkbox"/>	<input type="checkbox"/>
5. Has daytime toileting accidents	<input type="checkbox"/>	<input type="checkbox"/>
6. Repetitive flapping or spinning	<input type="checkbox"/>	<input type="checkbox"/>
7. Has poor eye contact	<input type="checkbox"/>	<input type="checkbox"/>
8. Doesn't play with other children	<input type="checkbox"/>	<input type="checkbox"/>
9. Is preoccupied with interests	<input type="checkbox"/>	<input type="checkbox"/>
10. Can't tolerate a change in routine	<input type="checkbox"/>	<input type="checkbox"/>
11. Is very sensitive to textures	<input type="checkbox"/>	<input type="checkbox"/>
12. Stares into space as if in a trance	<input type="checkbox"/>	<input type="checkbox"/>
13. Is easily frustrated	<input type="checkbox"/>	<input type="checkbox"/>
14. Has frequent tantrums	<input type="checkbox"/>	<input type="checkbox"/>
15. Rarely smiles, giggles, laughs	<input type="checkbox"/>	<input type="checkbox"/>
16. Has problem sleeping	<input type="checkbox"/>	<input type="checkbox"/>
17. Has unusual fears/nightmares	<input type="checkbox"/>	<input type="checkbox"/>
18. Sleepwalks	<input type="checkbox"/>	<input type="checkbox"/>
19. Eats things that aren't food	<input type="checkbox"/>	<input type="checkbox"/>
20. Goes on diets	<input type="checkbox"/>	<input type="checkbox"/>
21. Is aggressive to others	<input type="checkbox"/>	<input type="checkbox"/>
22. Is cruel to animals	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate if child has exhibited any of the following behaviors:

Past Present
Concerns Concerns

- | | | |
|--|--------------------------|--------------------------|
| 23. Running away from home | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Shoplifting / Stealing | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Frequent lying | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Depression / Sadness | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Isolation / withdrawal | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Irritability / anger | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Rapid / intense mood swings | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Explosive outbursts | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Significant weight change | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Appetite changes | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Excessive worries / anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Declining school grades | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Refusal to attend school | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Paranoid thinking | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Sudden recurrent motor movements
(blinking, shoulder shrugging, head jerking) | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Sudden recurrent vocalizations (chirping,
sniffing, snorting, coughing) | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Sexually Inappropriate behavior | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Has "melt downs" | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Has lost interest in doing fun activities | <input type="checkbox"/> | <input type="checkbox"/> |

III. CHILD'S PAST PSYCHIATRIC HISTORY

A. Please list your child's past psychiatric or psychological evaluations and/or therapy or counseling provided by school, physicians, clinics, counselors, or psychologists (include phone # if possible).

- Please note the **Date, Location, and Results** of the testing and/or therapy.

- **PLEASE BRING EVALUATIONS TO FIRST APPOINTMENT**

B. Has your child ever been hospitalized for psychiatric reasons? Yes No. If yes, please explain

C. Has your child ever attempted suicide? Yes No. If yes, please explain _____

Has your child ever engaged in self-injurious behaviors? Yes No. Please explain_____

D. Has your child ever been abused? None Physical Sexual Emotional

Has Child Protective Services and/or Family Advocacy Program ever been involved? Yes No.

If yes, please explain_____

E. Has your child ever drunk alcohol, used marijuana, abused prescription pain killers, or used other recreational drugs? Yes No. Please explain_____

Has the child ever misused or taken more medication than prescribed? Yes No. Please explain_____

Are there any substances you fear that your child may be abusing? Yes No. Please explain_____

Has your child ever used medication that was prescribed for someone else? Yes No. Please explain_____

Has your child ever received counseling for substance abuse? Yes No. Please explain_____

F. Please list any past psychiatric medications your child has taken:

Medication

For how long?

Reason for taking medication

What psychiatric medication is your child currently taking? _____

Are there any side effects from the medication/s that your child is experiencing? _____

IV. CHILD'S MEDICAL HISTORY

A. Child's physician's name: _____
Date of last comprehensive physical exam: _____
Has child seen any medical specialists such as cardiologists or neurologists? Yes No. Please explain

B. Has your child been hospitalized for medical reasons? Yes No. If so, why, when, where? _____

Has your child ever required surgery? Yes No. If so, why, when, where? _____

List any seizures, head injury, loss of consciousness/concussion, or neurological evaluations _____

C. Has your child ever experienced a physical trauma or injuries? Yes No
If yes, please explain: _____

D. Does your child have drug, food, or environmental allergies? Yes No If so, please describe.

E. Please indicate the child's currently level of pain:
No Pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Extreme Pain

Comments: _____

F. Please indicate if your child has had any of the following medical illnesses or problems.

Frequent ear infections	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	Fainting	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	Heart defect	<input type="checkbox"/>
Swallowing problems	<input type="checkbox"/>	Prior EKG	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	Encephalitis	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>
Ear Tubes	<input type="checkbox"/>	Low blood count/anemia	<input type="checkbox"/>
Cardiac arrhythmias	<input type="checkbox"/>	Accidents	<input type="checkbox"/>
Heart murmurs	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>

Other: _____

G. List any medication(s) your child is currently taking? Include over-the-counter medication, herbal supplements, diet pills:

<u>Medication</u>	<u>For how Long?</u>	<u>Reason for taking medication</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

H. To the best of your knowledge is your child sexually active? Yes No. Please explain _____

If child is a female, has menstrual cycle begun? Yes No. If yes, age of onset? _____

I. Nutritional History _____

- Any problems with chewing, swallowing, choking, feeding? Yes No _____
- Any food allergies/intolerance? Yes No _____
- Any weight gain or weight loss of 10 lbs in the past 6 months? Yes No _____
- Any concerns that your child may have an eating disorder? Vomiting? Excessive dieting? Excessive exercising? Low caloric intake? Yes No _____
- Would you like to discuss nutritional issues with a dietician? Yes No _____

V. PREGNANCY AND BIRTH HISTORY

A. Prenatal History - (Questions refer to the pregnancy of the child who is being evaluated.)
Please recall the following the best you can:

	Yes	No	Comment
Was this child a planned pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did the mother ...			
take any medication during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	_____

smoke cigarettes during the pregnancy? _____
 drink alcohol during the pregnancy? _____
 use any other drugs during pregnancy? _____

Were there any complications occur during the pregnancy?

B. Labor History:

Was the baby full term? Yes No If not, how many weeks old at birth? _____
 Were there any problems with delivery? Yes No. Please explain _____
 Was delivery induced or spontaneous? _____
 Were forceps used? Yes No _____
 Nuchal cord? Yes No _____
 Meconium staining? Yes No _____
 What was the birth weight of the child? _____
 Length of stay in hospital: Mother: _____ days Child: _____ days

C. Infant's Condition at Birth: _____

Any problems shortly after birth? _____

VI. DEVELOPMENTAL and SKILL PROFILE

A. Between the ages of 0 and 2-years-old, was your child:

- Extremely sensitive to slight changes in touch, sound level, lighting, etc? Yes No
- Unable to develop a regular sleeping pattern? Yes No
- Impossible or very difficult to soothe or calm self when distressed/upset? Yes No
- Unable to separate from parents without extreme distress? Yes No
- Unable to show affection? Yes No

B. Check the boxes as appropriate to describe developmental milestones

<u>Milestone</u>	<u>Age achieved</u> (if known)	<u>Early</u>	<u>On time</u>	<u>Late</u>	<u>Don't Know</u>
Walked alone		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Said first words		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime toileting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder training		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel training		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tied shoelace		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrote name		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. What are your child's strengths? _____

D. Please list your child's leisure time activities (i.e. sports, clubs, internet use, social networking sites): _____

E. Please list any problems with use of TV, internet, or cell phone: _____

F. What is your family's religious or spiritual affiliation? _____
Does your child have religious, spiritual, or cultural practices your provider needs to be aware of during treatment? _____

VII. EDUCATIONAL HISTORY

A. Name of current school _____ Location: _____

Grade _____

Teacher or Counselor's name _____ Phone # _____

B. How many schools has your child attended?

C. What are the average grades your child receives? _____

-Has child repeated a grade or subject? Yes No What grade or subject? _____

-Please list any subjects your child is currently failing, if any: _____

D. Has child been suspended or expelled? Yes No If "Yes," please explain _____

E. Has your child received any special education services (IEP) or other academic support like 504 plan?

Yes No _____

If so, **PLEASE BRING THE IEP TO YOUR FIRST APPOINTMENT** and briefly describe below.

Any history of Occupational Therapy, Speech Therapy, or Counseling in the school setting?

F. Please indicate any problems your child has in school:

Reading	<input type="checkbox"/>	Spelling	<input type="checkbox"/>
Writing	<input type="checkbox"/>	Math	<input type="checkbox"/>
Does not get along with teachers	<input type="checkbox"/>	Does not get along with students	<input type="checkbox"/>

VIII.	FAMILY SOCIAL & MEDICAL HISTORY
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A. Does this child have other parent(s) and/or stepparent(s)? Yes No
 If yes, please provide the following information:

Name	Relationship to this child	Location (city, state)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Please list everyone living in household:

Name (last, first)	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

C. If the patient has any other siblings not living with him/her, please list them below.

Name (last, first)	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Who is the child's primary care giver? Name: _____

E. How many hours per day is your child in a child-care setting? _____

F. If child is not living with biological parents please list why: _____

G. Please indicate on the chart below anyone in the child's biological family who has a history of any of the problems listed below. (If child is not living with biological parents, please include health information on biological parents if known):

	Child's Father	Father's Family	Child's Mother	Mother's Family	Child's Siblings
Attention Difficulties and/or Hyperactivity	<input type="checkbox"/>				
Learning Difficulties	<input type="checkbox"/>				
Mental retardation	<input type="checkbox"/>				
Autism	<input type="checkbox"/>				
Problems with alcohol and/or drugs	<input type="checkbox"/>				
Seizures/convulsions	<input type="checkbox"/>				
Cardiac defects/arrhythmias	<input type="checkbox"/>				
Tourette's syndrome	<input type="checkbox"/>				
Eating Disorder	<input type="checkbox"/>				
Nervousness or anxiety	<input type="checkbox"/>				
Schizophrenia	<input type="checkbox"/>				
Bipolar (Manic/Depressive) Disorder	<input type="checkbox"/>				
Nervous Breakdown	<input type="checkbox"/>				
Mental Health Hospitalization	<input type="checkbox"/>				
Depression/Other mental health problems	<input type="checkbox"/>				
Self-mutilation	<input type="checkbox"/>				
Suicide	<input type="checkbox"/>				
Sudden Death	<input type="checkbox"/>				
Legal Problems (Incarceration)	<input type="checkbox"/>				

Other: _____

H. Please tell us of any significant stressors your family has experienced in the past year.

Death in the family	<input type="checkbox"/>	Deployment	<input type="checkbox"/>
Divorce or separation	<input type="checkbox"/>	Work stressors	<input type="checkbox"/>
Significant illness or injury	<input type="checkbox"/>	Financial problems	<input type="checkbox"/>
Child or Spouse abuse	<input type="checkbox"/>	Legal problems	<input type="checkbox"/>

Other stressors: _____

I. Please list any parental deployments lasting for 3 months or more and indicate any observed behavior changes in your child:

<u>Age of Child</u>	<u>Deployment Location</u>	<u>Length of Deployment</u>	<u>Behavior changes (if any)</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

4. _____

5. _____

6. _____

J. To what extent do you and your spouse generally agree on how to discipline your child?

Never agree ① ② ③ ④ ⑤ *Always agree*

K. What methods of discipline do you typically use?

Time-out	<input type="checkbox"/>	Ground	<input type="checkbox"/>
Take privileges (TV, games, allowance)	<input type="checkbox"/>	Yell	<input type="checkbox"/>
Give rewards for doing well	<input type="checkbox"/>	Spank	<input type="checkbox"/>
“1-2-3 Magic” or other behavior course	<input type="checkbox"/>		

Other methods used: _____

IX. RISK ASSESSMENT

A. Are there any firearms in any homes where your child resides? Yes No

B. Is there any history of domestic violence in the home? Yes No
If yes, has the family ever been referred to CPS or FAP? Yes No

C. Does your child have a history of homicidal (harm to others) thoughts or behaviors?
 Yes No

D. Does your child have current homicidal (harm to others) thoughts or behaviors?
 Yes No

E. Does your child wear seat belt? Yes No

F. Does your child have history of suicidal thoughts or behaviors? Yes No

G. Does your child have current suicidal thoughts or behaviors? Yes No

H. Do you have other safety concerns at this time? Yes No

Please explain any “Yes” answers _____