

Northland Psychiatric Specialists, L.L.C.

New Patient Intake Form

For Children and Adolescents

Date of Appointment: \_\_\_/\_\_\_/\_\_\_  
Month Date Year

Today's Date: \_\_\_/\_\_\_/\_\_\_  
Month Date Year

**Patient Information:**

Patient's Name: \_\_\_\_\_  
First Middle Last Nickname (if applicable)

Patient's Birthdate: : \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Month Date Year

Address: \_\_\_\_\_  
Number and Street City State Zip

Telephone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Your Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

**Mother's Information:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
First Middle Last

Address (if different from child's): \_\_\_\_\_  
Number and Street City State Zip

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Occupation: \_\_\_\_\_ Place Employed: \_\_\_\_\_

Marital Status:

- Single       Married       Divorced       Widowed



If yes please specify \_\_\_\_\_

Has your child taken any medications in the past for behavioral problems? \_\_\_\_\_

If yes please specify \_\_\_\_\_

Why was the medication discontinued? \_\_\_\_\_

Does your child have any drug allergies? \_\_\_\_\_

If yes please specify the allergy and reaction \_\_\_\_\_

Has your child ever had surgery? \_\_\_\_\_

If yes please specify what surgery and when \_\_\_\_\_

\_\_\_\_\_

Medical and Surgical History	Yes	No	NA
Has your child ever had any heart problems?			
Has your child ever had any broken bones?			
Has your child ever had any concussions or head injuries?			
Has your child ever had any seizures?			
Does your child have frequent headaches?			
Has your child ever had any seasonal allergies?			
Has your child ever had asthma?			
Has your child ever had any complications from drug or alcohol abuse?			
Has your daughter ever had any menstrual problems?			

Has your child every had any heart problems, if yes then please specify \_\_\_\_\_

\_\_\_\_\_

Have there been any heart problems or sudden cardiac death in the family? \_\_\_\_\_

If yes then please specify \_\_\_\_\_

Are there any other health problems, if yes please specify? \_\_\_\_\_

\_\_\_\_\_

Developmental History	Yes	No	NA
Was this a surprise pregnancy?			
Any illnesses during pregnancy?			
Any general anesthetics during pregnancy?			
Did you smoke cigarettes during pregnancy?			
Did you use any alcohol or street drugs during pregnancy?			
Was the delivery full term?			

Were there any problems during pregnancy? If yes please specify \_\_\_\_\_

\_\_\_\_\_

How many weeks were you at delivery? \_\_\_\_\_ Any problems with the delivery? \_\_\_\_\_

If yes then please specify \_\_\_\_\_

Child's Weight at birth \_\_\_\_\_ Any complications after the delivery? \_\_\_\_\_

If yes then please specify \_\_\_\_\_

Was your child slow in?	Yes	No	NA
Sitting?			
Walking?			
Saying words?			
Using sentences?			
Toilet training?			
Did your child have problems socializing with others?			

### Behavioral Problems:

Does you child currently have or has he/she ever had:	Yes	No
Problems with sleeping		
Appetite change or sudden weight change		
Irritability or temper outbursts		
Depressive statements (for example: "I wish I was dead")		
Not coping in school like before		
Withdrawn or prefers being alone		
Frequent complaints of aches or pains		
Recent drop in grades		

Phobia or irrational fears		
Difficulties separating from you		
Bouts of severe anxiety or panics		
Repetitive behaviors (for example: washing hands, checking locks)		
Pulling out hair or eyelashes		
<b> </b>		
Episodes of unusually high energy or talkativeness		
Attention problems		
Impulsive behaviors		
Easily distracted from what he/she is doing		
Hyperactive according to the teacher		
Abnormal movements (for example: jerking or eye blinking)		
Excessive noises (for example: throat clearing or sniffing)		
Bossy		
Refuses to do what he/she is told		
Problems with the law		
Expelled or suspended from school		
Running away from home		
Setting fires		
Hurting animals or other people		
Stealing		
Abnormal lying		
Smoking		
Drinking		
Illegal drug use		
Inappropriate sexual behavior		
Ever been sexually abused		
Ever been physically abused		
<b> </b>		
Slow to learn		
Ever suspected of being mentally retarded		
Ever suspected of being autistic		
Plays with toys or other objects in an unusual way		
Head bangs, flaps, twirls, or rocks		
Injuries him/herself (for example: bangs head, bites, or hits him/herself)		
Resistant to change		
<b> </b>		
Talk to him/herself		
Have any imaginary friend		
Ever appear to be hearing voices or seeing visions		
Appear paranoid or afraid of others		
Have any odd ideas or beliefs		
Ever tried to kill themselves or others		

### Past Psychiatric History:

Has your child ever seen a psychiatrist before? \_\_\_\_\_

If yes who and when? \_\_\_\_\_

Has your child ever seen a psychologist, therapist, or counselor before? \_\_\_\_\_

If yes who and when? \_\_\_\_\_

Has your child ever been admitted to the hospital for psychiatric treatment? \_\_\_\_\_

If yes when and what for? \_\_\_\_\_

### Family History:

Are there any psychiatric illnesses in the family (example: parents, siblings, grandparents?) \_\_\_\_\_

If yes then please specify \_\_\_\_\_

Are there any alcohol or drug problems in the family? \_\_\_\_\_

If yes then please specify \_\_\_\_\_

Any suicides in the family, please specify \_\_\_\_\_

### Educational History:

		Any problems?	
Schools attended	For what grades	Yes	No

Describe any problems brought to your attention by your child's teachers: \_\_\_\_\_  
\_\_\_\_\_

Any recent changes in grades, please specify \_\_\_\_\_

## Social History:

If your child is adopted, how old was he/she when the adoption occurred? \_\_\_\_\_

If your child is adopted, do you have any information about his/her biological parents? \_\_\_\_\_

Does your child have any brothers or sisters? \_\_\_\_\_

If yes please complete the table below:

Name	Age	Sex	Where do they live?	Biological Status (example: full, half, step sibling)

Does anyone else besides parents and siblings live in the home? \_\_\_\_\_

If yes then please specify \_\_\_\_\_

Are there any significant problems in the home?	Yes	No
Separation of parents		
Divorce		
Violence or abuse		
Drugs		
Alcohol		
Financial difficulties		
Eviction/Foreclosure		
Court cases/legal problems		
Unemployment		
Physical illness		