University Healthcare Physicians
Behavioral Medicine and Psychiatry
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Child and Adolescent Psychological Assessment and Intake History

Please fill out the following completely and to the best of your ability. If you have copies of previous evaluations or school records (e.g., IEP, 504-Plan, etc) please feel free to bring them.

CONFIDENTIAL

Today's Date: _____

Patient's Name: _____ Birthdate: _____ Age: _____

Sex: _____ Race: _____ Ethnicity: □ Hispanic □ Non-Hispanic

Primary Address: _____

Biological Mother's Name: _____ Mother's Age: _____

Mother's Occupation: _____ Length of Employment: _____

Mother's Address: _____

Telephone: (Day) _____ Permission to leave a message? □ Yes □ No

(Evenings) _____ Permission to leave a message? □ Yes □ No

Biological Father's Name: _____ Father's Age: _____

Father's Occupation: _____ Length of Employment: _____

Father's Address: _____

Telephone: (Day) _____ Permission to leave a message? □ Yes □ No

(Evenings) _____ Permission to leave a message? □ Yes □ No

Current Status of Biological Parents: □ Married (Date of Marriage _____)

□ Separated (Date of Separation _____)

□ Divorce (Date of Divorce _____)

□ Never Married (Legal Custodian: _____)

Legal custody of children*: _____ Physical custody of children: _____

*If there is a custody agreement, please attach documentation verifying legal custody.

Please list information about your child's siblings (including step-siblings):

Name	Age	Relationship

Please list other individuals currently living in the home:

Name	Age	Relationship

Within your household/ family, with who does your child get along best? _____

Are there other relatives or adults that are important caretakers to your child (i.e. stepparent, significant other, and grandparent)? Please list:

Name	Age	Relationship

Are their firearms within the home? □ Yes □ No

If yes, how are they stored? _____

Does your family feel safe in the neighborhood where you live? □ Yes □ No

If no, please explain: _____

Current Symptoms Checklist:

( ) Sleep pattern disturbance	( ) Racing thoughts	( ) Excessive worry	( ) Anxiety Attacks
( ) Unable to enjoy activities	( ) Impulsivity	( ) Depressed Mood	( ) Avoidance
( ) Increase in risky behavior	( ) Hallucinations	( ) Loss of Interest	( ) Suspiciousness
( ) Concentration/forgetfulness	( ) Excessive guilt	( ) Change in appetite	( ) Crying spells
( ) Decreased need for sleep	( ) Excessive Energy	( ) Fatigue	( ) Increased irritability
( ) Defiance	( ) Aggression	( ) Outbursts/ Tantrums	

Other_____

School

Current School: _____ Date began: _____

Grade: _____ Teacher(s): _____

Does your child receive special education services? □ No □ Yes

If yes, please explain: _____

_____

Has your child ever repeated a grade? □ No □ Yes - If yes, which grade(s): _____

Has your child ever skipped a grade? □ No □ Yes - If yes, which grade(s): _____

Has your child ever failed a class? □ No □ Yes - If yes, which class (es): _____

Has your child ever been evaluated for learning problems before? □ No □ Yes

If yes, please explain: _____

Was a diagnosis made? □ No □ Yes - If yes, what diagnosis? _____

Has your child ever received accommodations, special services, or been placed in a special resource room? □ No □ Yes - If yes, what grades? _____

Please described resources: _____

Has your child ever received individual tutoring? □ No □ Yes - If yes, what grades? _____

What subjects: _____

Please describe your child's academic performance (grades) in the following subjects:

Elementary School: Math _____ Science _____ English_____

Middle School: Math _____ Science _____ English_____

High School: Math _____ Science _____ English_____

Does your child get in trouble at school because of behavior? □ No □ Yes –

If yes, describe: _____

Do you/ your child get in trouble on the bus or in after-school programs because of behavior?

□ No □ yes – If yes, describe: _____

Which adults, if any, are involved in helping with homework? _____

Medical/Developmental History

General Physical Health: □ Excellent □ Good □ Fair □ Poor

Hand Preference: □ Left □ Right □ Ambidextrous

Does your child wear corrective lenses (e.g. glasses or contacts)? □ No □ Yes

Does your child require a hearing aid or have any hearing impairment? □ No □ Yes

Has your child received regular check-ups, eye exams, and hearing exams? □ No □ Yes

Does your child currently take any prescription medications? □ No □ Yes

If yes, please list medication and dosage: _____

_____

Is your child currently receiving any counseling services? □ No □ Yes

If yes, where? _____

Has your child received counseling services in the past? □ No □ Yes

Is yes, when and where? _____

Describe any prenatal complications or complications in your child's birth or infancy? _____

_____

Were there any delays in your child obtaining developmental milestones (e.g., crawling, walking, talking, etc.)? □ No □ yes - If yes, please explain: _____

_____

Leisure & Social History

Is your child involved in any extracurricular and/ or community activities? □ No □ Yes

If yes, please describe: _____

Does your child have any hobbies or special interests? ? □ No □ Yes

If yes, please describe: _____

How do you/ How does your child spend free time, relax, and/ or have fun? _____

_____

What is your child good at? _____

How many close friends do you/ does your child have? □ None □ 1-2 □ 3-5 □ More than 6

Age of closest friends: □ Mostly younger □ mostly same age □ Mostly older □ Mix of ages

Where does your child spend time with friends? □ School □ Neighborhood □ Other: _____

Outside your household/ family (children and adults), with whom does your child get along best?

_____

Family Health History

Have any family members been diagnosed with the following:

Learning Disability □ No □ Yes - Name(s): _____

ADD/ADHD □ No □ Yes - Name(s): _____

Mental Retardation □ No □ Yes - Name(s): _____

Depression □ No □ Yes - Name(s): _____

Anxiety □ No □ Yes - Name(s): _____

Psychiatric Illness □ No □ Yes - Name(s): _____

Are there any medical conditions that run in your family? □ No □ Yes

If yes, please explain: _____

_____

Is there anyone in your family who you are particularly worried about now? □ No □ Yes

If yes, please explain: _____

Have you or anyone else in your family been treatment and/or have problems with alcohol or substance abuse? □ No □ Yes – Name(s): _____ When: _____

Diagnosis: _____

Have there been past or present concerns regarding domestic violence, physical, or sexual abuse in your family? □ No □ Yes

If yes, please explain: _____

Has someone close to your family/ your child been victimized by violence? □ No □ Yes

If yes, please explain: _____

_____

Suicide Risk Assessment:

Has your child ever had feelings or thoughts your child didn't want to live? ( ) Yes ( ) No

If NO, please skip to next page. **If YES, Please answer the following:**

- **Do you currently feel that you do not want to live**? ( ) Yes ( ) No
- How often do you have these thoughts? _____
- When was the last time you had thoughts of dying? _____
- Has anything happened recently to make you feel this way? _____
- On a scale of 1 – 10 (ten being the strongest) how strong is the desire to kill yourself currently? _
- Would anything make it better? _____
- Have you ever thought about how you would kill yourself? _____
- Is the method you would use readily available? _____
- Have you planned a time for this? _____
- Is there anything that would stop you from killing yourself? _____
- Do you feel hopeless and/or worthless? _____
- **Have you ever tried to kill or harm yourself before?** _____

Substance Use:

Has your child ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substance? _____

If yes, where were you treated and when? _____

Do you think your child may have a problem with alcohol or drug use? ( ) Yes ( ) No

Has your child used street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Has your child abused prescription medications? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Check if your child has ever tried any of the following:

( ) Methamphetamine ( ) Cocaine ( ) Stimulants ( ) Heroin ( ) Hallucinogens
( ) Marijuana ( ) Ecstasy ( ) Methadone ( ) Alcohol
( ) Pain killers (not prescribed) ( ) Tranquilizer/sleeping pills ( ) other

_____

Tobacco History:

Has your child ever smoked cigarettes? ( ) Yes ( ) No

Has your child ever used smokeless tobacco (chewing tobacco)? ( ) Yes ( ) No

ALLERGY AND MEDICATION LIST

Patient Name: _____ Date of Birth: _____

Allergies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Current Medications: (Including Supplements, Vitamins, and Herbal Medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____