University Psychiatric Practice Incorporated
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Psychiatric Intake Form

(All information on this form is strictly confidential)

Please complete all information on this form to the best of your ability and bring it to the first visit.

Today's date:_____

Source of information: Child◯, Parent◯, Other ◯, relationship:_____

Name:_____ Date of birth:_____

Age:_____ Sex: M◯ F◯

Primary phone number:_____ May I leave a message at this number? Y◯ N◯

Secondary phone number:_____ May I leave a message at this number? Y◯ N◯

Street address:_____

City:_____ Zip code:_____

Emergency contact:_____

Phone number:_____ Relationship:_____

Names of all people with whom the child lives and their relationship to the child:

_____
_____
_____
_____

Names of all other immediate family members (parents, siblings) who do not live at home with the child:

_____
_____

Is the child adopted? Y◯ N◯. Are the child's parents separated? Y◯ N◯

Current school:_____ Grade:_____

Approximately how many students are in the child's class?_____

Does the child have a 504 plan? Y◯ N◯ or Individualized Education Plan (I.E.P.)? Y◯ N◯

List the problems for which the child is to be seen:

_____
_____
_____
_

What are the child's primary stressors right now?

_____

_____

_____

What are the goals for treatment?

_____

_____

_____

Psychiatric History

Has the child ever received a mental health diagnosis? Y◯ N◯. If yes, list below:

_____

_____

Has the child ever been hospitalized for a mental health problem? Y◯ N◯ If yes, list below:

Dates of hospitalization Hospital Diagnosis/problem

_____

_____

_____

Has the child ever been treated by a psychiatrist and/or therapist before Y◯ N◯. If yes, list below:

Dates of treatment Psychiatrist/therapist/facility Diagnosis/problem

_____

_____

_____

Is the child currently receiving professional counseling or any kind of psychotherapy Y ( ) N ( )

If yes, name of counselor/therapist:_____

Phone number:_____ Address:_____

If the child has ever taken psychiatric medications, please indicate the medication, dates used, dosage used, if they were helpful to the child, and what side effects (if any) the child experienced. Below and on the next page are a list of psychiatric medications to assist you.

Medication Dates Dosage Helpful (Y/N) Side effects

_____

_____

_____

Examples: Methylphenidates (Concerta, Ritalin, Focalin, Methylin, Metadate), Amphetamines (Adderall, Vyvanse, Dexedrine), Guanfacine (Tenex, Intuniv), Clonidine (Catapres, Kapvay), Atomoxetine (Strattera), Fluoxetine (Prozac), Sertraline (Zoloft), Escitalopram (Lexapro), Citalopram (Celexa), Fluvoxamine (Luvox), Paroxetine (Paxil), Venlafaxine (Effexor), Duloxetine (Cymbalta), Bupropion (Wellbutrin), Trazodone (Desryel), Mirtazepine (Remeron), Clomipramine (Anafranil), Amitriptyline

(Elavil), Lithium (Eskalith), Valproate (Depakote), Carbamazepine (Tegretol), Lamotrigine (Lamictal), Risperidone (Risperdal), Aripiprazole (Abilify), Quetiapine (Seroquel), Olanzapine (Zyprexa), Paliperidone (Invega), Clozapine (Clozaril), Haloperidol (Haldol), Fluphenazine (Prolixin), Alprazolam (Xanax), Lorazepam (Ativan), Clonazepam (Klonopin), Hydroxyzine (Vistaril), Buspirone (Buspar)

Trauma History

Has the child ever had a traumatic experience? Y ◯ N ◯. If so, list below:

_____

Has the child experienced any significant losses? Y ◯ N ◯. If so, list below:

_____

Has the child ever been the victim of verbal abuse Y ◯ N ◯, physical abuse Y ◯ N ◯, or sexual abuse Y ◯ N ◯

Has the child ever been the victim of bullying Y ◯ N ◯, or cyber-bullying Y ◯ N ◯?

Suicide Risk Assessment

Have you (the child) ever had thoughts that life wasn't worth living, that you didn't want to go on, or that you might want to kill yourself? Y ◯ N ◯

If yes, please answer the following. If no, please skip to Family Psychiatric History.

Have you (the child) had specific thoughts about wanting to be dead? Y ◯ N ◯

What, if anything, has happened recently to make you (the child) feel like this?_____

_____

Have you (the child) ever developed a plan about how you would kill yourself? Y ◯ N ◯

Is the method you (the child) would use readily available? Y ◯ N ◯

Have you (the child) ever tried to hurt or kill yourself before? Y ◯ N ◯

Are there any firearms in your (the child's) home? Y ◯ N ◯

Is there anything that would stop you (the child) from killing yourself?_____

_____

What do you (the child) feel you can look forward to?_____

_____

Family Psychiatric History

Has anyone in the child's family been diagnosed or treated for the following (continues to next page):

Diagnosis Y/N Family member(s)

ADHD_____

Depression_____

Anxiety_____

Bipolar disorder_____

Suicide_____

Autism spectrum disorder_____

Obsessive compulsive disorder_____

Anger/Disruptive behavior_____

Schizophrenia/Psychosis_____

Posttraumatic stress disorder_____

Alcohol or substance use_____

Eating disorder_____

Has anyone in the child's family been treated with a psychiatric medication? Y ◯ N ◯. If so, what medication was taken and was it helpful?_____

_____

_____

Medical Information

Allergies to medications:_____

Other allergies:_____

Current prescription medications, including dosages and how often they are taken (if none, write "none").

_____

_____

_____

Girls only: Is the child using birth control? Y ◯ N ◯. Method:_____

Current over-the-counter medications and supplements (if none, write "none"):_____

_____

Current medical problems (on the next page are a list of some medical problems to assist you):

_____

_____

_____

Asthma, Diabetes, acid reflux, cancer, Hypo/Hyperthyroidism, anemia, kidney disease, liver disease, heart problems, heart rhythm problems, stomach problems, Crohn's disease, migraines, seizures, high blood pressure, high cholesterol, traumatic brain injury, stroke

Past medical problems, hospitalizations, and surgeries:_____

_____

_____

Pediatrician/Primary health care provider:_____

Phone number:_____ Address:_____

Date of last physical exam:_____ Has the child ever had an EKG? Y ◯N◯ Date:_____

Has the child ever had any head imaging (CT, MRI) or an EEG done? If so, list below, including dates:

_____

_____

Is there a history in the child's family of any medical problems? If so, list below:

_____

_____

_____

Substance Use & Legal History

For each substance listed below, please indicate whether the child has tried the substance, how often he/she uses the substance, and the last time he/she used the substance.

Substance	Tried (Y/N)	How often?	Last time used?
Alcohol			
Marijuana			
Cigarettes			
E-cigarettes			
Cocaine			
Methamphetamine			
Pain pills (not prescribed)			
Heroin			
Benzodiazepines (not prescribed)			
Other substances			

Has the child ever received treatment for substance or alcohol use? Y ◯N ◯ If so, list below:

Dates of treatment	Facility	Substance(s)

Has the child ever been arrested before? Y ◯N◯

Thank you for the taking the time to fill out this form. This information will be very helpful in assisting me in the treatment process. I look forward to working with you.