Dr. Jackson's Medical Psychology Intake Form

NEW PATIENT CHILD/ADOLESCENT REGISTRATION

CHILD'S NAME:_____NICKNAME:_____
DATE OF BIRTH___/___/____ Age:_____ GENDER:FEMALE/MALE HANDEDNESS:[R] [L] [BOTH]
ADOPTED: Y/N IF YES, AT WHAT AGE:____ IS ADOPTION KNOWN BY CHILD _____
MOTHER:_____AGE:_____DOB:_____
ADDRESS:_____
PRIMARY PHONE:_____OTHER PHONE:_____WORK PHONE:_____
EMPLOYER:_____CAN MESSAGE BE LEFT AT WORK?: Y/N

FATHER:_____AGE:_____DOB:_____
ADDRESS:_____
PRIMARY PHONE:_____OTHER PHONE:_____WORK PHONE:_____
EMPLOYER:_____CAN MESSAGE BE LEFT AT WOR?: Y/N

CHILD'S PRIMARY CARE PHYSICIAN:_____
NAME OF CLINIC:_____
PHONE:_____FAX:_____
ADDRESS:_____

HOW DID YOU HEAR ABOUT US? [ ]PRIMARY CARE PHYSICIAN ABOVE [ ]FRIEND [ ]INSURANCE COMPANY [ ]INTERNET
[ ]ANOTHER PHYSICIAN_____

EMERGENCY CONTACT:
NAME:_____
RELATIONSHIP:_____PHONE:_____

Please place a recent picture of your child here->
It will not be returned to you.

Parent/Guardians Signature Date

Witness

CHILD/ADOLESCENT QUESTIONAIRRE PLEASE COMPLETE ALL SECTIONS

PATIENT NAME:_____DOB:_____

Briefly describe the problems your child is having and when they began:

_____
_____
_____
_____
_____

MENTAL HEALTH HISTORY

Has your child ever been abused (emotionally, physically, or sexually)? [ ]Yes [ ]No Please explain:

_____
_____
_____
_____

Has your child ever experienced any other emotional or physical trauma: [ ]Yes [ ]No Please explain:

_____
_____
_____

Has your child: (a) Been in counseling [ ]Yes [ ]No

(b) Been hospitalized for emotional or alcohol/drug problems [ ]Yes [ ]No

(c) Been professionally evaluated [ ]Yes [ ]No

(d) Received special education services [ ]Yes [ ]No

If yes to any of the above, please provide dates, names of agencies, reasons for service and outcome.

_____
_____
_____
_____

Please list any family history of mental health/substance abuse problems:

_____
_____

****************************Please bring your child's medications to the first session*************************

Please list any medications your child has taken in the past for emotional/behavioral problems: [ ]None

_____
_____
_____

GENERAL MEDICAL HISTORY

This medical form should be completed by the parent/guardian of the child being evaluated or treated at Northshore Counseling and Wellness. Please complete the form, sign and date.

Please list all allergies your child has to medications or other substances such as dyes or food:_____

_____

_____

1. Are your child's immunizations up to date? [ ]Yes [ ]No
2. Has your child ever passed out during exercise? [ ]Yes [ ]No
3. Has your child ever had any dizziness during or after exercise? [ ]Yes [ ]No
4. Has your child ever had unexplained pain during or after exercise? [ ]Yes [ ]No
5. Does your child get tired more quickly than friends during exercise? [ ]Yes [ ]No
6. Has your child ever complained of racing or skipping heart beats? [ ]Yes [ ]No
7. Have you ever been told your child has high blood pressure? [ ]Yes [ ]No
8. Have you ever been told your child has a heart murmur? [ ]Yes [ ]No
9. Have any family members died of heart problems or of sudden unexpected death before the age of 50? [ ]Yes [ ]No
10. Have any family member or your child been diagnosed with:
    a. Enlarged Heart [ ]Yes [ ]No
    b. Hypertrophic Cardiomyopathy [ ]Yes [ ]No
    c. Long QT Syndrome [ ]Yes [ ]No
    d. Marfans Syndrome [ ]Yes [ ]No
    e. Brugada Syndrome [ ]Yes [ ]No
    f. Wolfe Parkinson White Syndrome [ ]Yes [ ]No
    g. Idiopathic Ventricular Fibrillation [ ]Yes [ ]No
    h. Catecholaminergic Polymorphic Ventricular Tachycardia [ ]Yes [ ]No
    i. Cardiac Conduction Defect [ ]Yes [ ]No
11. Is your child missing any paired organs? [ ]Yes [ ]No
12. Does your child have frequent headaches? [ ]Yes [ ]No
13. Has your child had any concussions or head injury? [ ]Yes [ ]No
14. Has your child had seizures? [ ]Yes [ ]No
15. Does your child have a genetic disorder? [ ]Yes [ ]No
16. Is your child currently taking any prescription medications? [ ]Yes [ ]No
    List them:_____
    _____
17. Is your child taking any over the counter medications? [ ]Yes [ ]No
    List them:_____
    _____
18. Does your child have any chronic or current medical conditions? [ ]Yes [ ]No
    List them:_____
    _____

I have reviewed my family's and child's history and attest the medical history form is accurate.

_____ _____

Parent/Guardian Signature Date

FAMILY STATUS

1. Are the child's biological parents currently married? [ ]Yes [ ]No

   If yes, what year?_____

   If no, custody is with: [ ]Mother [ ]Father [ ]Joint [ ]Other_____

**********Please produce documentation of custody orders**********

Please describe living arrangements, visitations, etc.:_____
_____
_____

List all people currently living in your home and the relationship to your child:_____
_____
_____

Are there any traditions or events that are important or traumatic for your child?_____
_____
_____

Is there any additional information you feel would be helpful to the treatment of your child?_____
_____
_____

DEVELOPMENTAL HISTORY

Was your child's pregnancy planned? [ ]Yes [ ]No

Please check any of the following experienced during the pregnancy of the child being evaluated:

[ ] Excessive vomiting [ ]X-rays [ ]Toxemia [ ]Infection

[ ] Smoking [ ]Drug Use [ ]Alcohol consumption [ ]Prescription medications

[ ] Illness [ ]Threatened Miscarriage [ ]Preclampsia

[ ]Hospitalization(other than delivery) [ ]Full term delivery [ ]Premature_____weeks [ ]Late_____weeks

Please describe any problems with the pregnancy or delivery:_____
_____
_____

EARLY CHILDHOOD

Milestones ~ Please report the ages, or if you cannot remember, check one of the following:

Smiled	[ ]Early [ ]Average [ ]Late	Age___
Crawled	[ ]Early [ ]Average [ ]Late	Age___
Sat up	[ ]Early [ ]Average [ ]Late	Age___
Stood alone	[ ]Early [ ]Average [ ]Late	Age___
Walked unassisted	[ ]Early [ ]Average [ ]Late	Age___
Spoke first words	[ ]Early [ ]Average [ ]Late	Age___
Said sentences	[ ]Early [ ]Average [ ]Late	Age___
Toilet trained	[ ]Early [ ]Average [ ]Late	Age___
Ran	[ ]Early [ ]Average [ ]Late	Age___
Fed self	[ ]Early [ ]Average [ ]Late	Age___
Dressed self	[ ]Early [ ]Average [ ]Late	Age___

Were there any illnesses, behavioral difficulties, or discipline problems during early childhood?_____
_____
_____
_____

Did your child have temper tantrums? [ ]Yes [ ]No If yes, please describe:_____
_____
_____
_____

What discipline techniques were used?_____
_____
_____
_____

Do you, as parents, use consistent discipline? [ ]Yes [ ]No

EDUCATIONAL HISTORY

Current school:_____Grade:_____

How many different schools has your child attended?_____

Has your child repeated or skipped a grade? [ ]Yes [ ]No Describe, if yes:_____
_____

What is her/his attendance like at school? [ ]Poor [ ]Good If attendance is poor, please explain:_____
_____

Has she/he had any discipline problems at school and/or been suspended or expelled from any school? [ ]Yes [ ]No

Explain:_____
_____
_____

What are her/his grades like? [ ]Below average [ ]Average [ ]Above average [ ]Excellent

Have their grades changed recently? [ ]Yes [ ]No If yes, please explain:_____
_____

With what subjects does she/he experience difficulty?_____
_____

Has she/he been diagnosed with a learning disability? [ ]Yes [ ]No

Does she/he attend special education services? [ ]Yes [ ]No

Briefly describe any special services being provided for your child in preschool/school:_____
_____
_____

**************************Please bring any school assessments to your first appointment**********************

SOCIAL HISTORY

Does your child make friends easily? [ ]Yes [ ]No

Does your child have difficulty keeping friends? [ ]Yes [ ]No

Briefly describe any peer interaction problems experienced by your child:_____
_____
_____

Have there been any recent losses, changes or transitions in your child's life? [ ]Yes [ ]No If yes, please describe:_____
_____
_____

Does the family have any spiritual, cultural or religious beliefs that influence the child?_____
_____
_____

Please describe your child's strengths, weaknesses, accomplishments, talents and areas of interest:_____
_____
_____
_____

I HAVE READ EACH QUESTION AND COMPLETED THE FORM TO THE BEST OF MY ABILITY.

_____

PARENT/GUARDIAN