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Child & Adolescent Introductory Form

Patient Name: _____

Patient Age: _____ Patient Date of Birth:____/____/____ Gender: _____

Guardian Name: _____ Relationship to the Patient: _____

Current Address:_____

Email: _____ @_____

Preference for Appointment Reminders: [ ]Text [ ] Email [ ] Do not send reminders

Emergency Contact's Name: _____

Emergency Contact's Relationship to the Patient: _____

Emergency Contact's Phone Number: _____

Primary Care Physician's Name: _____ Phone #: _____

Are you or family member currently involved in any court case? Y N

If yes, describe: _____

_____

_____

Chief Complaint:

_____

_____

_____

_____

History of Present Illness:

_____

_____

_____

_____

_____

_____

Attempted Solutions and Efficacy:

Treatment History

Psychiatric Hospitalizations

Hospital	Dates	Reason	Outcome

Psychiatric Outpatient

Provider	Dates	Reason	Outcome

Psychiatric Medications Tried

Medication	Dose	Dates	Response

Current Medications

Prescriber	Medication	Dose	Start Date	Response

Family and Living Arrangements

Other People Currently Residing with Patient

Name	Age	Gender	Relationship	Grade/Occupation

Other Important Family Members or Significant Support People

Name	Age	Gender	Relationship	Grade/Occupation

Important Family Events: _____

_____

_____

_____

Developmental History

Pregnancy ended: [ ] at term **[ ]** _____weeks premature **[ ]** _____ weeks late

Activity level of patient prior to birth: [ ] normal **[ ]** under active **[ ]** overactive

Mother's health during pregnancy: [ ] normal **[ ]** Complications

If complications, explain: _____

_____

Labor & Delivery: [ ] normal **[ ]** breech **[ ]** occiput posterior (face up) **[ ]** emergency caesarean

[ ] routine caesarean **[ ]** other complications (please explain): _____

_____

Milestones: [ ] Normal **[ ]** Advanced **[ ]** Delayed

Additional information about Milestones: _____

_____

_____

Allergies: _____

_____

_____

History of Abuse: _____

_____

_____

_____

_____

_____

Medical/Surgical History:

[ ] no prior illnesses except usual childhood diseases

Illnesses (List and explain): _____ **at age:** _____

_____ **at age:** _____

_____ **at age:** _____

Sexually Active: [ ] No [ ] Yes If Female, Number of Pregnancies _____ Deliveries_____

Other Relevant Details of Pregnancies and/or Deliveries: _____

_____

_____

_____

Tobacco/Nicotine Use [ ] No [ ] Yes If yes, how much: _____

Caffeine Use: [ ] No [ ] Yes If yes, how much: _____

Alcohol Use: [ ] No [ ] Yes If yes, how much: _____

Marijuana Use: [ ] No [ ] Yes If yes, how much: _____

Other Substance Use: [ ] No [ ] Yes If yes, please explain substance of choice, frequency, and quantity of use: _____

Family History

[ ] No Serious Illnesses

History of Serious Illnesses in Immediate Family: _____

_____

_____

_____

[ ] No Serious Psychiatric Illnesses

History of Serious Psychiatric Illnesses in Family: _____

_____

_____

_____

[ ] No Legal History

Family Legal History (Contact with Department of Social Services, Police, etc.): _____

_____

_____

Cultural Influences: _____

_____

Educational History

Current School: _____ **Grade:** _____

History of Repeated Grades and Reason: _____

_____

Current Academic Performance: _____

_____

_____

History of Behavioral Issues in School: _____

_____

_____

Attitude Toward School: _____

_____

Treatment Goals

Three Goals of the Patient: _____

_____

_____

_____

Three Goals of Parent/Guardian: _____

_____

_____

_____

Parent/Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

Provider Signature: _____ **Date:** _____