ALLISON HOLT & ASSOCIATES
CHILD, ADOLESCENT & ADULT PSYCHIATRY AND THERAPY
Change is within reach.

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Child & Adolescent Clinic Intake Questionnaire

NOTE: Please download this form and open in Adobe Acrobat prior to completing. Please also limit your descriptions to 500 characters. Additional comments will be discussed at your appointment. Thank you.

Please complete this questionnaire and bring it with to your child's first appointment. It asks about general background information that may be relevant to your child's evaluation.

Child's Name: **Age:**

Date of Birth: **Grade:** **School:**

Child's Nickname (if any):

Today's Date:

Name of Person completing form and relationship to child:

CHILD DEVELOPMENT

Note any complications related to the following in the space provided:

Pregnancy

(e.g., medications taken, drugs/alcohol, illness, complications?)

Labor

(e.g., spontaneous, induced, duration?)

Delivery

(e.g., C-section, forceps, distress, APGARS?)

Birth weight: Went home with mother? ☐ Yes ☐ No (reason):

Neonatal/Infancy

(e.g., jaundice, convulsions, colic, problems breathing, infections?)

As a baby, my child was (check all that apply):

☐ calm	☐ active	☐ difficult	☐ good sleeper	☐ easily upset	☐ affectionate
☐ quiet	☐ loud	☐ difficult to care for	☐ ate well	☐ stubborn	☐ predictable

Print Form

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Estimate the age at which your child could:

Walk | Catch a ball

Speak Words | Tie shoelaces

Speak simple sentences | Toilet trained | Day | Night

If any of the following occurred as a young child, note the age:

Nonsense speech or made-up words | Poor pronunciation

Repeating other's speech | Clumsiness

Ignored people or other children | Withdrawn

If any of the following occurred as a young child, note the age:

Odd movements | Head-banging

Nightmares, night terrors | Bedwetting (after age 6)

Excessive anxiety about separation from parents | Excessive anxiety about going to school

Repeating behaviors excessively, e.g. twirling in circles, lining up toys

If there was testing or therapy for any of the following, note the child's age and where testing/therapy was received:

Speech

Vision

Hearing

Learning

Neurological

Is child receiving special services at school? ☐ Yes ☐ No

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Current or Previous Psychiatric/Mental Health/Counseling Interventions (Please note age and where/with whom):

Current Medications:

Current Medications	When Started	Doctor/Prescriber	Effects

Please complete the following describing any PAST trial of psychiatric medication, in chronological order if possible:

Past Medications	When Started	Doctor/Prescriber	Effects

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GENERAL MEDICAL HISTORY

Primary physician and/or clinic:

Would you like us to share information with this provider? ☐ No ☐ Yes If so, please complete a release of information)

Date last seen:

Note the age of onset and details related to any of the following conditions that apply to your child:

	Allergies to Medications	
	Surgeries	
	Hospitalizations	
	Serious illnesses	
	Head injuries	
	Seizures or Convulsions	
	Meningitis, Encephalitis, or Coma	

Any current Medical Problems:

Please check any current health issues that apply to you and describe:

General	Eyes	Ears/Nose/ Mouth/Throat	Cardiovascular	Respiratory	Gastrointestinal	Genitourinary	Genitourinary
☐ weight	☐ blurry	☐ dry mouth	☐ chest pain	☐ shortness of breath	☐ heartburn	☐ hesitancy	☐ stiffness
☐ appetite	☐ flashes	☐ congestion	☐ dizziness	☐ cough	☐ nausea	☐ retention	☐ swelling
☐ fatigue	☐ dry	☐ headache	☐ swollen feet	☐ wheezing	☐ constipation	☐ menses	☐ aches
☐ poor sleep	☐ pain	☐ ringing	☐ leg cramps		☐ diarrhea	☐ sexual	☐ injury

Neurological	Skin	Endocrine	Hematological	Immunologic
☐ movements	☐ rash	☐ too cold	☐ bruising	☐ hives
☐ weakness	☐ itching	☐ too warm	☐ bleeding	☐ congested
☐ tremor	☐ dry	☐ sweating	☐ nodes	☐ infections
☐ seizure	☐ hair loss	☐ thirst	☐ anemia	☐ rashes

Describe checked symptoms or others not listed:

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FAMILY HISTORY

Child lives with:
- ☐ Biological parents
- ☐ Adoptive parents
- ☐ Parent & stepparent
- ☐ Foster parents
- ☐ One parent alone
- ☐ Institution
- ☐ Relatives
- ☐ Other

Parents are:
- ☐ Married
- ☐ Unmarried
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Please describe parent' marital relationship, if applicable:
- ☐ Smooth
- ☐ Occasional difficulties
- ☐ Frequent difficulties
- ☐ Failure

Family Composition: Names, ages, and relation of everyone who lives at home:

Name		Age		Relation	
Name		Age		Relation	
Name		Age		Relation	
Name		Age		Relation	
Name		Age		Relation	
Name		Age		Relation	

Who has custody at this time?

Please describe agreement between parents on how to deal with child's problems:
- ☐ Usually agree
- ☐ Sometimes agree
- ☐ Never agree

Has anyone in the immediate or extended family needed help for emotional, behavioral, psychiatric or neurological problems or other serious medical problems? If so, please list and describe the problems as best as you can and the family member's relation to the child.

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Was the child exposed to any type of abuse (sexual, physical, emotional, verbal etc)? If so, describe type, by whom, duration:

Have any of the following events occurred which may have affected your child? Note when and describe:

Death in family/other losses:

Change in family's financial status:

Job changes:

Divorce or separation:

Moves:

Are there any significant events that occurred in either parent's upbringing that would be important for us to know in working with the family? (e.g., chemical dependency, chronic family fighting, abuse)

Has the child smoked cigarettes or used tobacco products? If yes, please describe:

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Has the child used alcohol or street drugs? If yes, please describe:

Any legal issues in the past or present? If so, please describe:

Any employment in the past or present? If so, please describe:

Please list any other information you feel is important for us to know:

Please list questions you would like answered at this appointment if possible:

1.
2.
3.
4.
5.