

NAME: _____

Date: _____

Ivy Collaborative Healthcare New Child/Adolescent Intake Form

What is/are the problem(s) for which you are seeking help for your child?

1. _____
2. _____
3. _____

List any recent family difficulties or upsetting events (ex. Illness or death of a family member or close relative, moves, financial challenges, family stress, abuse (emotional/sexual/physical))

What has been done to help these challenges? _____

What would you like to gain from working with us? What are your treatment goals? _____

Current Symptoms Checklist: (check once for any symptom **present**, check twice for major symptoms)

- | | | |
|---|--|---|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Unable to enjoy activities | <input type="checkbox"/> Loss of interest in pleasurable activities |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Concentration/forgetfulness |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Change in sleeping patterns | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Increase risky behavior | <input type="checkbox"/> Sleeping less |
| <input type="checkbox"/> Excessive energy | <input type="checkbox"/> Increased irritability | <input type="checkbox"/> Increased libido |
| <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Crying spells | <input type="checkbox"/> Unprovoked anxiety attacks |
| <input type="checkbox"/> Loss of interest in pleasurable activities | <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Paranoia | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Avoidance |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

DEVELOPMENTAL HISTORY:

In-utero exposure to: tobacco Illicit substances (alcohol, drugs) no exposure to tobacco/illicit substances

Delivery: Vaginal Caesarean Premature (before 37 weeks) On-time Late (after 41 weeks)

Verbal Milestones: Met Delayed **Motor Milestones:** Met Delayed

- MEDICAL HISTORY:** None Arthritis Asthma Bleeding Disorder
- Blood Clots (or DVT) Coronary Artery Disease Diabetes Heart Murmur
- Structural Heart Abnormality High Cholesterol High Blood Pressure Kidney Disease
- Thyroid Disease Head trauma Loss of Consciousness Concussion
- Seizures Other _____

ALLERGIES: include anything you are allergic to (medications, food, bee stings, etc) and how each affects you: None

Allergy

Reaction

Preferred Pharmacy/Location: _____

Preferred Lab/Location: _____

SOCIAL HISTORY:

Family Members at home (spouse, parents, children, siblings and/or other relatives):

- 1. Name _____ Relationship to the patient: _____
- 2. Name _____ Relationship to the patient: _____
- 3. Name _____ Relationship to the patient: _____
- 4. Name _____ Relationship to the patient: _____
- 5. Name _____ Relationship to the patient: _____

Education:

- Current school _____ Grade: _____
- IEP/504 in place now? No Yes Has the school done any special testing for services? No Yes _____
- Behavior/discipline issues at school: _____

Hobbies/Extracurricular activities/interests: _____

Smoking History: Never smoked Former Smoker Current Smoker _____ packs/cigars per day

Alcohol: Do you drink alcohol? No Yes. How often? Occasionally <3 times a week >3 times a week How many drinks per week? _____

List any Illicit Substance used on more than one time to get high, feel better or change your mood? None Yes. _____

Guns in the home?: No Yes Is gun safety being practiced?

PAST FAMILY PSYCHIATRIC HISTORY: List any family member (out to 'greats' or first cousins) who have been diagnosed with:

Depression: None _____

Anxiety: None _____

Bipolar: None _____

Schizophrenia: None _____

ADHD: None _____

Mental Retardation/Autism/Learning Disability: None _____

Substance Use (eg. alcohol, drugs): None _____

Has any family member died of sudden/unexpected death under 50yo (including but not limited to drowning, unexplained car accident, sudden infant death syndrome/SIDS)? Yes No

Has any member family died by suicide? Yes No

PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY OF PATIENT:

List ALL Psychiatric and Non-Psychiatric Medications taken regularly within the past 30 days (including over the counter, herbal medications, and vitamins) None

Name of Medication	How many milligrams (mg)?	When is it taken? (am, pm, twice a day, etc.)	Reason for medicine?
1			
2			
3			
4			
5			

List any previous Psychiatric Diagnoses: None _____

Previous **ALL Psychiatric Medications** tried in the past: None

Medication	Dose	Frequency (daily, as needed, etc)	Duration of treatment (ex. days, weeks, months, years)	Side Effect(s) (if any)
1)				
2)				
3)				
4)				
5)				

Psychiatric Hospitalizations and/or Residential Treatment: None

Dates	Hospital	Reason for Hospitalization

Have you ever worked with a Psychiatrist before? Yes No Engaging in talk therapy before? Yes No

Please list their names and indicate what kind of treatment, when and how long were you were in treatment?

Have you ever tried to commit suicide in the past? No Yes (when/what age?) _____

Have you every tried to hurt yourself in the past? No Yes (when/what age?) _____

Any history of violent behavior? No _____ Yes (when/what age?) _____

REVIEW OF SYSTEMS: Please check(✓) all **problems** you are experiencing **TODAY:**

Constitutional	Weight loss <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Poor appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight gain <input type="checkbox"/> Insomnia <input type="checkbox"/> Night sweats <input type="checkbox"/>
Eyes	Blurry vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye redness <input type="checkbox"/> Decrease in vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Double vision <input type="checkbox"/>
ENT	Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Tinnitus <input type="checkbox"/> Sinus problems <input type="checkbox"/>
Cardiovascular	Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid heart rate <input type="checkbox"/> Heart murmur <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling in the legs or feet <input type="checkbox"/>
Respiratory	Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> History of Tuberculosis <input type="checkbox"/> Excess sputum production <input type="checkbox"/>
Gastrointestinal	Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in the stool <input type="checkbox"/> Frequent heartburn <input type="checkbox"/> Trouble swallowing <input type="checkbox"/>
Genitourinary	Increased urinary frequency <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful urination <input type="checkbox"/> Urinary retention <input type="checkbox"/> Frequent UTI's <input type="checkbox"/>
Skin	Rash <input type="checkbox"/> Hives <input type="checkbox"/> Hair loss <input type="checkbox"/> Skin sores or ulcers <input type="checkbox"/> Itching <input type="checkbox"/> Skin thickening <input type="checkbox"/> Nail changes <input type="checkbox"/> Mole changes <input type="checkbox"/>
Psychiatric	Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Alcohol or drug dependence <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Panic attacks <input type="checkbox"/> Use of anti-depressants <input type="checkbox"/>
Neurological	Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Migraines <input type="checkbox"/> Numbness <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Loss of balance <input type="checkbox"/> Slurred speech <input type="checkbox"/> Stroke <input type="checkbox"/>
Heme/Lymphatic	Low blood count <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Transfusions <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Blood clots <input type="checkbox"/>
Allergic/Immune	Allergic reactions <input type="checkbox"/> Hay fever <input type="checkbox"/> Frequent infections <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV positive <input type="checkbox"/> Positive tuberculin skin test (PPD) <input type="checkbox"/>

Thank you for completing this form

Who may we thank for your referral (Physician, Nurse, Teacher, Counselor, Family, Friend): _____

Your signature serves as a comprehensive signature acknowledgement for the following forms and policies. Please access the patient portal or the practice's website to review and print your documents or they can be printed for you upon request. You further acknowledge that you have read, understand and accept each policy in its entirety.

✓ HIPPA Privacy Notice ✓ Financial Policies ✓ Notice of Privacy Practices

Patient Signature: _____ **Date:** _____

(To be signed by patient's parent or legal guardian)

Reviewed by Physician/APRN: _____ **Date:** _____