ORLANDO PSYCHIATRIC ASSOCIATES

ORLANDO: 2345 SAND LAKE ROAD, SUITE 200.
ORLANDO, FL 32809.
TEL: (407) 851-5121, FAX: (407) 851-0439

OCOEE:1551 BOREN DR. UNIT B. OCOEE, FL 34761
TEL: (407) 532-4940, FAX: (407) 532-4946

Intake form for Child and Adolescents

(PLEASE PRINT)

Patient Contact Information

Patient Name _____ Age _____ Date of Birth _____
Last First Mi

Address _____

Primary Care Physician _____ Tel _____ Fax _____

Pharmacy Name _____ City_____ Zip _____ Phone # _____

Parents are: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed

If divorced, what are the custody arrangements? _____
(Please bring the copy of custody agreement)

Where was your child born and raised _____

Please list other children in the family _____

Current School: _____ Grade Level: _____

What are your child's academic strengths? _____
Academic weaknesses? _____
What are the problems you are seeking help for? _____
What are your treatment goals? _____
Has your child ever been a victim of abuse or neglect? ☐ Yes ☐No
If yes, what was the nature of the abuse?_____
Are you struggling with your marital relationship or parenting? ☐Yes ☐No
Child Protective Services? ☐Yes ☐No
Probation/ Juvenile Probation/ Detention ☐Yes ☐No

Check current or recent issues that do or have existed for your child:

☐ Anger outburst ☐ Aggressive behavior at home ☐ Aggressive behavior at school ☐ Destruction of property
☐ Irritable ☐ Throws tantrums ☐ Refuses to listen to parents ☐ Argues with adults
☐ Doesn't follow rules at home ☐ Doesn't follow rules at school ☐ Skips school ☐Suspension from school
☐ Stealing ☐ Frequent lying ☐ Expressed desire to run away ☐ Has run away ☐ Impulsive
☐ Has difficulty paying attention/easily distracted ☐ Has difficulty staying on task ☐ Doesn't finish tasks ☐ Poor concentration
☐ Hyperactive (difficulty sitting still) ☐ Need to repeat self when asking him/ her to do something
☐ Needs academic support ☐ Lately grades are dropping ☐ Overly sensitive to stimuli ☐ Tilts his/ her head to look at items
☐ Day time toilet accidents ☐ Repetitive flapping or spinning ☐ Has poor eye contact ☐ Doesn't play with other children
☐ Preoccupied with interests ☐ Can't tolerate a change in routine ☐ Frequent tantrums
☐ Rarely smiles, giggles, laughs ☐ Eats things that aren't food ☐ Shy around strangers ☐ Low self-image
☐ Low self-esteem ☐ Does not think anyone likes him/ her ☐ Upset by family conflict
☐ Gets along with same age peers ☐ Has same age peer friends ☐ Prefers to play with younger kids
☐ Has friends younger than his/ her age ☐ Talks about imaginary friends ☐ Does not have friends ☐ Gets teased
☐ Gets into fights with peer age kids ☐ Argues that he/ she is always right ☐ Negative outlook on life
☐ Anxious ☐ Worries a lot/ ruminates ☐ Tearful/ cries easily ☐Sensitive to what others say about him/ her
☐ Afraid to speak in public ☐ Socially awkward or anxious ☐ Hair twirling ☐ Hair pulling ☐ Head banging
☐ Bed wetting ☐ Panic attacks ☐ Avoids certain activities ☐ Avoids certain places
☐ Engages in repetitive behaviors ☐ Perfectionist ☐ Moody ☐ Depressed ☐ Very happy without cause
☐ Does not seem to have fun ☐ Has extreme fears or phobias ☐ Has threatened to hurt self
☐ Has talked about killing self ☐ Has engaged in self- injurious behavior ☐ Has attempted suicide
☐ Has difficulty falling asleep ☐ Has difficulty staying asleep ☐ Has nightmares ☐ Has or had night terrors
☐ Appetite/ weight change ☐ Eating issues ☐ Recently experienced a death in the family
☐ Recently experienced the death of a friend ☐ Recently parents separated ☐ Recently parents divorced
☐ Recently parent lost a job ☐ Recently changed schools ☐ Recently moved from home ☐ Lies
☐ Steals ☐ Smokes ☐ Sexually acting out ☐ Legal problems ☐ Drinks alcohol ☐ Uses drugs
☐ Other issues otherwise not listed? _____

ORLANDO PSYCHIATRIC ASSOCIATES

ORLANDO: 2345 SAND LAKE ROAD, SUITE 200.
ORLANDO, FL 32809.
TEL: (407) 851-5121, FAX: (407) 851-0439

OCOEE:1551 BOREN DR. UNIT B. OCOEE, FL 34761
TEL: (407) 532-4940, FAX: (407) 532-4946

Pregnancy/ Birth History/ Developmental History

Was this child a planned pregnancy? ☐Yes ☐ No Comment_____

Smoked cigarettes during pregnancy? ☐ Yes ☐ No Comment _____

Consumed alcohol/ drugs during pregnancy? ☐ Yes ☐ No Comment_____

Any complications during pregnancy? ☐ Yes ☐ No

Was the baby full term? ☐ Yes ☐ No If no, how many weeks old at birth?_____

Was this a normal delivery? ☐ Yes ☐ No

Childs birth weight: _____

Any problems shortly after birth? ☐ Yes ☐ No

Developmental History:

At what age did your child start walking? _____

At what age did your child start talking? _____

At what age was your child potty trained? _____

Has your child ever seen a Therapist/Psychiatrist? If yes, please list: _____

Previous Psychiatric history: Has your child ever been treated for any of the following (check all that apply)

_____Autism	____ Learning Disability	
_____ Depression	_____ ADHD	_____ Bipolar (Manic / Depressive) Disorder
_____ Anxiety	_____ OCD	_____ Schizophrenia
_____ Panic Attacks	_____ PTSD	_____ Alcohol Problems (including AA)
_____ Anorexia/ Bulimia	____ Binge-eating	_____ Drug Problems _____

Please list in chronological order all prior psychiatric hospitalizations (if any) below: None

Has he/she attempted to harm self? If so, please list the occurrences below: Never

Approximate date of attempt	How did you attempt (method)?

4. Please list all current medications below

Medication	Dosage(Mg)	Times a day?	How long?	(if any)	Physician

ORLANDO PSYCHIATRIC ASSOCIATES

ORLANDO: 2345 SAND LAKE ROAD, SUITE 200.
ORLANDO, FL 32809.
TEL: (407) 851-5121, FAX: (407) 851-0439

OCOEE:1551 BOREN DR. UNIT B. OCOEE, FL 34761
TEL: (407) 532-4940, FAX: (407) 532-4946

Please list previous psychiatric medications below

Medication	Dosage(Mg)	Times a day?	How long?	(if any)	Physician

5. Medical Information:

Is your child allergic to any medication? If yes, please list: _____

Date of last physical Exam:_____

Name of PCP_____ Tel:_____

Has your child experienced any of the following medical conditions during his/her life time?

☐ Allergies ☐ Asthma ☐ Headaches ☐ Head Injury ☐ Meningitis Seizures

☐ Serious Accidents ☐ Hearing Problems ☐ Diabetes ☐ Heart Problems

☐ Gastric Problems

Has your child ever had an EEG, MRI CT SCAN, etc.? ☐ Yes ☐ No

If yes, why was it done and were the results normal? _____

Ever seen a Neurologist? ☐ Yes ☐ No

If yes, what was the reason? _____

Last menstrual period (if applicable):_____

Contraceptive method (if applicable):_____

Family History: Has anyone in your family treated for mental illness?

	Father	Mother	Aunt	Uncle	Brother	Sister	Grandparent
Depression	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Panic Attacks	☐	☐	☐	☐	☐	☐	☐
Post-traumatic stress	☐	☐	☐	☐	☐	☐	☐
Bipolar/Manic depression	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Alcohol Problems	☐	☐	☐	☐	☐	☐	☐
Drug Problems	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐
Suicide attempts	☐	☐	☐	☐	☐	☐	☐
Psychiatric hospital stay	☐	☐	☐	☐	☐	☐	☐