PSYCHOLOGICAL AFFILIATES
Dr. Nathan Townsend

Child/Adolescent Intake Information

IDENTIFYING INFORMATION

Child's Name_____
Last First Middle

Home Address:_____
Street City State Zip

Phone:_____/_____/_____
Home Work Cell

Parent's Names: _____

If parents are divorced or deceased: Year Divorced _____ Year Deceased_____

Is this a foster home placement? _____ Is this child adopted?_____

Please list siblings (Clarify if living in home by "IN" beside name):

_____ Age: _____ DOB ____/____/____ Gender ___ Choose One
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Parent's email address:_____ Social Security #:_____-____-_____

Child's D.O.B.____/_____/_____ Age:____ Sex:____ Place of Birth:_____

School Child Attends: _____ Grade: _____

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122 Cherry St. Marietta, Ga 30060
(770) 427-2911

Parent's Employer:_____ Position _____

Referral Source: _____/_____
Name Address

Person to contact in case of emergency:_____ Telephone:_____

PROBLEM IDENTIFICATION

What is your major concern that led you to seek help?

_____

_____

What do you think may be contributing to the problems? _____

_____

What has been done by you or others to help with the problem? Was it helpful?_____

_____

_____

What other concerns do you have?

_____

_____

DEVELOPMENTAL HISTORY

Where there any unusual conditions associated with pregnancy? _____

_____

Any complications at birth? _____

Did your child ever have any difficulties with colic, feeding, sleeping, chronic ear infections, or any other chronic complaints?

_____

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At what age did your child walk?_____ First words?_____ Sentences?_____

Do you consider your child's speech/language develop similar to peers? _____

_____

SYMPTOMS

Please answer "yes" or "no" and briefly describe any "yes" answers to the questions below.

Is your child consistently down or has a depressed mood most of the day or nearly every day? ____Yes ____ No _____

Does your child have a diminished level of interest in most or all activities? ____ Yes ____ No

_____

Change in appetite? ____Yes ____ No _____

Change in weight? ____ Yes ____ No _____

Change in sleep pattern? ____ Yes ____ No _____

Bed wetting? ____Yes____No_____

Headaches? ____Yes_____No_____

Fatigue or loss of energy? ____ Yes ____ No _____

Feelings of worthlessness or excessive guilt? ____ Yes ____ No_____

Difficulty thinking or concentrating? ____ Yes ____ No _____

Thoughts of death or suicide (or any attempts)?____ Yes ____ No _____

Increased irritability or violent behavior?____ Yes ____ No _____

Attacks of hyperventilation, palpitations or intense fear? ____ Yes ____ No _____

Any phobias or unusual fears? ____ Yes ____ No _____

Ever experience a "natural high" in absence of substance abuse (with increased energy, mood, decreased need for sleep, talkativeness, etc.)? ____ Yes ____ No

Any history of alcohol and/or drug use? (Briefly describe)

_____

_____

Has your child ever experienced any traumatic events? (Briefly describe)

_____

_____

Has your child ever been in therapy or completed psychological testing? (provide, dates and describe issues)

_____

_____

ACADEMIC/SOCIAL HISTORY

Has your child experienced any academic difficulty? If yes, please list specific grades and concern.

_____

_____

On an average how much time does your child spend daily on homework?_____

Has your child received any special education, additional tutoring, speech therapy, etc…? _____

_____

What thoughts or feelings has your child expressed about his/her problems at school?_____

_____

What do you see as your child's strengths and weakness? _____

_____

Has your child had any behavioral issues or concerns? If yes, have these concerns affected school, social, or home functioning? Please describe._____

_____

_____

Does your child have age appropriate friends? Do you have any social concerns regarding your child? _____

_____

_____

What are your child's responsibilities/chores at home and how well does he/she follow through with these? ___

_____

_____

Has your child had any involvement with the legal system? _____

_____

MEDICAL HISTORY

Has your child ever had any major medical problems (i.e. thyroid, diabetes, seizures, asthma, injuries etc.)?

_____

_____

Has your child ever had any prior hospitalizations (give date, reason, type of treatment)?

_____

_____

Is your child currently under the care of a physician and/or psychiatrist? If so, whom? And for how long?

_____

_____

Please list all medications he/she is currently or has recently taken. Give names, dosage and duration of usage.

_____

_____

Does your child have any allergies?_____Yes_____No_____

Family history of emotional, attention, or other mental health/substance abuse problems (even if no treatment was received).

RELATIVE **PROBLEM**

_____

_____

_____

Height _____ Weight _____ Highest Weight _____ Lowest Weight _____

Is there anything else that would be helpful for me to know about?

_____

_____

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Date	Parents Signature

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