9550 Hickman Road, Suite 101
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Phone: 515-758-8300
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PEDIATRIC PSYCHIATRIC EVALUATION INTAKE FORM:

DEMOGRAPHICS:

1. **PATIENT CONTACT INFORMATION**

Last Name_____ First Name _____MI_____

Preferred Name _____ Pronouns_____

Gender_____ Sexual Orientation_____

Address_____City/State/Zip_____

Best contact phone number _____Email address _____

Primary Care Physician _____Tel_____Fax_____

Pharmacy _____ Pharmacy Phone #_____

2. **DATE OF BIRTH _____ / _____ / _____**

3. **AGE _____**

4. **RACE / ETHNICITY (check one or more):**

☐ American Indian/Alaskan Native ☐ Asian ☐ African American
☐ Hispanic ☐ Caucasian ☐ Other _____

5. **MOTHER'S NAME: _____**

6. **FATHER'S NAME: _____**

7. **STEP PARENT'S OR OTHER GUARDIAN NAME: _____**

8. **Parents Marital Status?**

☐ Single, never married ☐ Married, living together ☐ Married, not living together
☐ Widowed ☐ Divorced ☐ Other _____

9. **If your parents are divorced, who has**

Physical custody ☐ Mom ☐ Dad

Legal Custody: ☐ Mom ☐ Dad

What is the current living arrangement?

☐ Primarily live with mom ☐ Primarily live with dad ☐ Split time 50/50

☐ Other _____

10. **How many siblings do you have?** _____
11. **Do all of your siblings live in the same house?** _____
12. **Who else lives with you?** _____
13. **Do you have any pets? How many? What kind?**_____
14. **What grade are you in?** _____
15. **Academic Performance (i.e. grades, learning difficulties):**

    _____

    _____
16. **Behavior at School (i.e. disciplinary issues, friendships):**

_____

_____
17. **Extracurricular activities and interests:**

_____

_____

REFERRED BY:_____

REASON FOR REFERRAL:_____

MENTAL HEALTH HISTORY:

1. **Describe the primary reason for seeking psychiatric care:**

_____

_____
2. **When did these concerns first begin?**_____
3. **How have these concerns impacted daily life? (i.e. school, home, social relationships)**

_____

_____
4. **Are you currently seeing a therapist? (NAME/CONTACT PHONE #):**

    _____

5. **Have you ever seen a psychiatrist/Psychotherapist before? If yes, please list:**

_____

6. **Previous History: Have you ever been treated for any of the following? (Check all that apply):**

☐ Depression ☐ Anxiety ☐ ADHD ☐ OCD ☐ Panic Attacks

☐ PTSD ☐ Oppositional Defiant Disorder ☐ Conduct Disorder

☐ Anorexia/Bulimia ☐ Binge-eating ☐ Autism Spectrum Disorder

☐ Learning Disorder (ex. Dyslexia, Dysgraphia)

Please List in chronological order all prior psychiatric hospitalizations (if any below):

NONE (circle if N/A)

Approximate Date:	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list below:

NEVER (circle if N/A)

Approximate date of attempt	How did you attempt (method)

Please list ALL current medications below (include birth control pills, over the counter medications, herbal remedies – i.e. St. john's Wort, decongestants, etc)

NONE (circle if N/A)

Name of Medication	Dosage (mg)	How many times a day?	On this for how long?	Side effects (if any)	Prescribing Physician

FAMILY HISTORY: Has anyone in your family ever been treated for any of the following (please check all that apply and when appropriate PATERNAL or MATERNAL)

NONE (circle if N/A)

	Father	Mother	Brother	Sister	Children	Grandparent
Depression						
Anxiety						
Panic Attack						
PTSD						
Bipolar Type I						
Bipolar Type III						
Schizophrenia						
Alcohol Addiction						
Drug Addiction						
ADHD						
Suicide Attempts						
Psychiatric Hospitalization						

DEVELOPMENTAL HISTORY:

Pregnancy or Birth History:

Complications: ☐ Yes ☐ No

Explain:_____

Birth Weight:_____**Premature**? ☐ Yes ☐ No **How early?**_____

Developmental Milestones:

Crawling:_____**Walking:**_____**Talking:**_____

Delays noted: ☐ Yes ☐ No If yes, please describe_____

MEDICAL HISTORY:
Current or past medical conditions?

NONE (circle if none)

_____

_____

SURGICAL HISTORY:
Please list all prior surgeries and hospitalizations for medical illness

NONE (circle if none)

_____

_____

ALLERGIES:
Please list all allergies to medications or food

NONE (circle if none)

_____

_____

FAMILY/HOME ENVIRONMENT:

Are there any recent changes in the family (i.e. divorce, death, relocation):

_____

_____

Are there any safety concerns at the home?

_____

_____

Anything else you believe is important for us to know about?

_____

_____

SUBSTANCE USE / ABUSE:
Is there any concern for substance use or abuse? ☐ Yes ☐ No

What substances do you use or have used in the past?

_____

_____

When was the last time you used this substance(s)?

_____

_____

At what age did you start using this substance(s)? _____

EMERGENCY CONTACT:_____ **PHONE:**_____

FINANCIAL HISTORY:

Responsible Party ☐ Self ☐ Parent/Guardian ☐ Spouse

Full Name_____**Gender** MALE / FEMALE

Date of Birth_____ / _____ / _____ **Phone**_____

Method of Payment ☐ Self-Pay ☐ Insurance

PRIMARY INSURANCE

Insurance Company_____ **Policy/Member ID**_____

Group Number_____ **Insurance Phone Number**_____

Relationship to Policy Holder ☐ Self ☐ Parent/Guardian ☐ Spouse

Full Name_____**Gender** MALE / FEMALE

Date of Birth_____ / _____ / _____ **Phone**_____

Policy Holder Address_____**City**_____**State**____**Zip**____

SECONDARY INSURANCE

Insurance Company_____ **Policy/Member ID**_____

Group Number_____ **Insurance Phone Number**_____

Relationship to Policy Holder ☐ Self ☐ Parent/Guardian ☐ Spouse

Full Name_____**Gender** MALE / FEMALE

Date of Birth_____ / _____ / _____ **Phone**_____

Policy Holder Address_____**City**_____**State**____**Zip**____

CREDIT CARD AUTHORIZATION FORM WILL BE SENT SEPARATELY. Please note we do keep a card on file for all patient accounts, to be able to better facilitate virtual appointments and past due balances.

IF NOT REFERRED, HOW DID YOU HEAR ABOUT US?

_____