Greenlake Psychiatric Services
6800 E. Green Lake Way N
Seattle, WA 98115

CHILD INTAKE INFORMATION

Intake Date ____________________

Patient Name: ____

Address: ____
Street City State Zip

Guardians: ______________________ ________ ______________________ ________
Name Age Name Age

Guardians' Address if different: ____

Phone (Home): (____)____________________ Phone (Cell): (_____)________________

(_____)________________

Date of Birth: ______________________Age: _______ Sex: _______
School:____________________________ Grade: _______

Guardian's Present Employer/Address: ____
Occupation: ______________________________
Education: ______________________________ Driver's License #: ________________

Guardian's Present Employer/Address: ____
Occupation: ______________________________
Education: ______________________________ Driver's License #: ________________

Names/Ages/Sex of Siblings. Please indicate if any siblings reside in other that the child's residence.

______________________ _____ _____ ______________________ _____ _____
______________________ _____ _____ ______________________ _____ _____
______________________ _____ _____ ______________________ _____ _____

Form of Payment: Insurance______________________________________Cash__________
Policy Holder's Name: ______________________ Relationship: ____________________
Group #: ______________________
Contract #: ______________________ Additional Info: ____________________

****FOR STAFF USE ONLY****

______________________________________ ____________________
Diagnosis Code

______________________________________ ____________________
Psychiatrist Signature
Print Name:______________________________

Insurance	Deductible	Copay	Yearly maximum	Lifetime max
Primary				
Secondary				

If applicable:
Authorization #:____________________Number of sessions:________Dates covered:____________________

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Please briefly state why this child was brought to the clinic. What are your concerns?

____

____

Has your child been seen by any other persons for this problem? Any previous hospitalizations or suicide attempts. Any current suicidal/homicidal thoughts? Any current psychiatric medications? Please explain.____________________

____

____

____

____

____

Education and School History

Please provide the following information for all schools that the child has attended:

School	Year started	Year stopped	Graduated?

What is your child's attitude about school? About the teacher(s)? About other students?_____________

____

____

How would you describe your child's performance and behavior at school? Are there any problems?

____

____

Developmental History

How would you describe the pregnancy with this child?____

____

Were there complications? If so, explain:____

____

Birth weight:___________________________________

Were there any difficulties in infancy with (please circle):

Feeding	Yes	No
Weight gain	Yes	No
Sleeping	Yes	No
Weaning from breast/bottle	Yes	No
Crying	Yes	No

When did your child first (age):

Sit	_______________________
Walk	_______________________
Say a word	_______________________
Say simple sentences	_______________________

Describe and give age of any significant illnesses, including ear infections, high fevers, operations, and/or accidental injuries:____

____

Describe any problem behaviors or personality difficulties as a preschooler:________________________

____

Has your child had any traumatic or potentially traumatic experiences? If so, explain:________________

____

During the past year, have there been any significant events which might have had a negative effect on your child? If so, explain.____

____

Legal Problems

Does the family have any pending legal problems? Yes No
Have you had prior legal problems in any way associated with your seeking treatment for your child at this time? Yes No
If yes to either of the above, please explain:____

____

Culture, Ethic, and Religious Information

Does your family or your child currently, or have you or your child in the past, practiced a particular religion?
Yes No

If yes, please provide additional information about the religion, your current level of involvement, and your anticipated interest in this in the future:____

____

Does your family identify with particular cultural or ethnic groups? Of what overall importance is this in your family's life?____

____

Present Family Constellation

Please list any other persons living with the family:____

____

Have there been any significant separation, divorces, deaths, etc., in the child's life?__________________

____

____

Activity Assessment

Approximately how much time does your child spend on play and leisure activities on a typical week day? ______________________ hours per day.

Approximately how much time does your child spend on play and leisure activities on a typical weekend (Saturday and Sunday?) ______________________ hours per day.

Is the amount of leisure time your child has available (check one):

Less than adequate______ Adequate_______ More than adequate_______ Much too much__________

With regards to the ways your child spends leisure time, would you say your child is (check one):

Very dissatisfied _____ Less than satisfied_____ Satisfied_____ More than satisfied______Very satisfied_______

Please list the activities in which your child is most active, starting with the activity in which he/she spends the most time? Include activities such as homework, individual or group play, chores, church activities, watching TV, computer, household projects, etc.)

Activity	**Approximate number of hours per week**
1.	
2.	
3.	
4.	
5.	
6.	

Are there activities you would like to see your child involved in? ___________________________________

____

Are there activities your child has expressed interest in, but is not presently involved in?______________

____

Medical History

Name, address, and phone number of current or most recent medical doctor:________________________

____

____

What was the date of your child's last physical examination? ___________________________________

Height:__________________________ Weight:_______________________

Please list all current medications:

Name of medication	Dose	Frequency taken	How long taken	Who prescribes

Please check "yes" or "no" to indicate whether or not your child uses the following non-medical or non-prescribed drugs. For "yes" answers, please indicate usage:

	Yes	No	How much	How long
Cigarettes				
Sleeping pills				
Tobacco				
Alcohol				
Marijuana				
Cocaine, crack				
Inhalants				
Stimulants (e.g., "uppers")				
Aspirin or other pain medication				
Cold remedies, cough medicine				
Coffee				
Tea				
Cola				
Other:				

Does your child have physical pain? Yes_____No_____
If yes, rate the intensity of the pain: 1(mild) to 5 (severe): ____________.
If yes, where is the pain located: ____.
If yes, how does it impact your child's functioning?____________________________________

____

Please check either "yes" or "no" to indicate whether or not the family has any of the following health problems. (Any unanswered questions will be considered a "no" response.)

	Child	**Mother**	**Father**	**Siblings**	**Extended family member**
Seizure disorder/epilepsy					
Glaucoma					
Emphysema					
Asthma					
Heart trouble					
High blood pressure					
Stomach trouble/ulcers					
Tuberculosis					
Thyroid disease					
Liver disease					
Gall bladder					
Hepatitis					
Diabetes					
Pancreatitis					
Cancer or tumor					
Arthritis or rheumatism					
Alcohol and/or drug abuse					
Stroke					
Anemia					
Depression					
Anxiety					
Mania or bipolar disorder					
Schizophrenia					
Learning disorder					
Attention deficit/hyperactivity disorder					
Other:					
Other:					

Is there any other medical, psychiatric, or substance abuse information that you feel we should know?

____

____

Is there anything else that you think we should know about your child or your family?________________

Signature:

____________________________________ __________________________
Guardian Date

CHILD/ADOLESCENT SYMPTOM CHECKLIST

Date:________________

Name of the child:__________________________________Date of Birth:_______________Age:__________

Name of the person completing this form:__________________________Relationship to child:________________________

Please circle the symptoms that apply to this child in the past few weeks:

Never Rarely Sometimes Always

Symptom						
Hyperactive	0	1	2	3	4	5
Fidgety	0	1	2	3	4	5
Difficulty sitting still	0	1	2	3	4	5
Short attention span	0	1	2	3	4	5
Easily distracted	0	1	2	3	4	5
Forgets easily	0	1	2	3	4	5
Does not turn in assignments	0	1	2	3	4	5
Disorganized	0	1	2	3	4	5
Poor grades	0	1	2	3	4	5
Academically behind	0	1	2	3	4	5
Learning difficulties	0	1	2	3	4	5
Speech problems	0	1	2	3	4	5
Reading difficulty	0	1	2	3	4	5
Math difficulty	0	1	2	3	4	5
Defies authority	0	1	2	3	4	5
Loses temper	0	1	2	3	4	5
Argumentative	0	1	2	3	4	5
Gets angry easily	0	1	2	3	4	5
Gets into fights	0	1	2	3	4	5
Throws or breaks objects	0	1	2	3	4	5
Problems with temper	0	1	2	3	4	5
Homicidal thoughts	0	1	2	3	4	5
Suicidal thoughts	0	1	2	3	4	5
Suicidal attempts, gestures	Yes/No					
Hurts animals	0	1	2	3	4	5
Lies	0	1	2	3	4	5
Sets fires	0	1	2	3	4	5
Steals, shoplifts	0	1	2	3	4	5
Breaks curfew	0	1	2	3	4	5
Runs away from home	0	1	2	3	4	5
Skips school	0	1	2	3	4	5
Smokes	0	1	2	3	4	5
Uses alcohol	0	1	2	3	4	5
Uses drugs	0	1	2	3	4	5
Legal problems	0	1	2	3	4	5
Is or has been on probation	0	1	2	3	4	5
Is or was in juvenile detention	0	1	2	3	4	5
Problem making or keeping friends	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5
Interrupted sleep	0	1	2	3	4	5
Early morning wakening	0	1	2	3	4	5
Oversleeping	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5
Irritability, edginess	0	1	2	3	4	5
Excessive worry	0	1	2	3	4	5
Low energy, tired	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Overeating	0	1	2	3	4	5
Weight gain or loss	0	1	2	3	4	5
If so, how much in the last 3-6 months: Gained______Lost_____						
Lack of interest in usual things	0	1	2	3	4	5
Difficulty separating	0	1	2	3	4	5
Won't sleep in own bed	0	1	2	3	4	5
Fears of ordinary things	0	1	2	3	4	5
For example, storms, crowds, doctor, germs, closed spaces, flying)						
Excessive hand washing	0	1	2	3	4	5
Rituals that child must do	0	1	2	3	4	5
For example, need to check and recheck; things in a certain order						
Counting behavior, thoughts	0	1	2	3	4	5
Need for organization, cleanliness	0	1	2	3	4	5
Anxiety, nervousness	0	1	2	3	4	5
Panic/anxiety attacks	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Stomachaches	0	1	2	3	4	5
Unexplained physical symptoms	0	1	2	3	4	5
Pain	0	1	2	3	4	5
Dizzy spells	0	1	2	3	4	5
Suspiciousness, paranoia	0	1	2	3	4	5
Hears voices (that others don't)	0	1	2	3	4	5
Sees things (that others don't)	0	1	2	3	4	5

Wets bed	0	1	2	3	4	5
Soils underclothing	0	1	2	3	4	5
Eating disorder	0	1	2	3	4	5
Picky eater	0	1	2	3	4	5
Binge-eating, purging	0	1	2	3	4	5
Anorexia	0	1	2	3	4	5
Trauma, other abuse	0	1	2	3	4	5

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