Greenlake Psychiatric Services
6800 E. Green Lake Way N 200
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
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

Revised 9/15