Cognitive Health Solutions LLC

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Child/Adolescent Intake History Form

Patient Name:		**Date of Birth:**	**Today's Date:**	
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Other:		**Gender:** ☐ Male ☐ Female		
Address:	Street:			
	City	State	Zip	
Phone Numbers (put only those we may call, and identify them as needed. Example: "mom's cell"):				
Home:		Mobile:		
Work:		Alternate:		
Employment : ☐ Employed ☐ Unemployed ☐ Full Time Student: Grade: ____ ☐ Part Time Student: Grade: _____				
If in school, what is the school name?				
Email Address (only provide if you are giving permission for us to email you):				
How would you like to receive appointment reminders?	☐ Email	☐ Call	☐ Text	☐ None, thank you.
Emergency Contact:	**Phone Number:**	**Relationship:**		
Address (if different):				

IF PATIENT IS A MINOR (contact information for BOTH parents is required)

Parent or Legal Guardian Name(s):	
Mother's Date of Birth:	**Father's Date of Birth:**
Parents' Marital Status: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated ☐ Other	
If separated/divorced, guardian with legal custody:	
Phone Number(s) (if different):	
Address (if different):	
If parents or guardians are separated or divorced, does a custody agreement exist? ☐Yes ☐No	***A copy of the custody agreement must be on file at our office.*** ***Consent of both parents is required when there is joint custody or when no custody agreement exists.***

Insurance Information: If you plan to use insurance for payment this information is needed to bill insurance company.

Insurance Company Name:	**Policyholder's name:**	
Insurance ID #:	**Group #:**	
Relationship to Patient:	**Policyholder DOB:**	**Employer:**

If the patient is covered under a secondary insurance policy please discuss this with the office staff.

History of Present Problem

Describe the main concerns or problems for this patient (symptoms, duration, frequency):

Describe the reason for seeking treatment at this time:

List any services or interventions you would like the patient to receive:

What do you/the patient hope to achieve through these services?

Past Psychiatric History

Has this patient received any of the following mental health or behavioral services before?

☐ Inpatient hospitalization	☐ Partial hospitalization
☐ Outpatient services	☐ Wraparound services
☐ Family-based mental health	☐ Residential treatment facility
☐ Drug and alcohol treatment	☐ MH/MR case management
☐ Medication prescription/management	☐ AA/NA attendance

☐ Other (explain):

Have they been given a prior diagnosis? If so, explain:

Trauma History

Has this patient ever experienced a trauma? Briefly explain:

Family Psychiatric History

Please note any family history of learning, developmental, attention, behavior, emotion, mental, or medical problems:

List agencies/caseworkers/clinicians currently working with patient/family on the problems noted above, if any:

Medical Conditions & History

How is this patient's overall health?	☐ Poor	☐ Fair	☐ Good	☐ Excellent

Please list any current or past health concerns (ex. Asthma, high fever, major surgery, hospitalization):

Approximate date of last physical examination:_____ Where/By Whom?	Have you suffered any head injuries? ☐ Yes ☐ No If yes, when?
List any allergies:	

Family History

Check all that best describe the patient's current living situation:

☐ Alone ☐ With Parent(s)/Guardian(s) ☐ With Family member(s) ☐ Adopted (Date):
☐ Temporary Custody ☐ Apartment ☐ House ☐ Homeless/Shelter ☐ Other:

Primary language spoken at home:

Is a second language spoken at home? What? Fluency: ☐ Fluent ☐ Limited ☐ None

Any major stresses in the family that have affected the patient (ex. death, divorce, etc.)?

List the names and information for all individuals living in the household (include caregivers, siblings, roommates, etc.):

Name	Age	Relationship	Comments/Concerns

Are there siblings living outside the patient's home? ☐ Yes ☐ No	If yes, list names, ages, and relationship:

Social History

Does this patient have problems getting along with others?	☐ Yes ☐ No
Does this patient have difficulty making and keeping friends?	☐ Yes ☐ No
Does this patient find being in a social situation difficult?	☐ Yes ☐ No
Does this patient interact better with adults than with children their age?	☐ Yes ☐ No

If you checked yes for any of the above questions, explain your response:

Developmental History

Please list any known developmental milestone delays:

Please indicate (estimate if unsure) the age at which the patient achieved the following milestones:

Sat upright alone:	Toilet trained:	Spoke in sentences:
Crawled:	Dry through night:	Learned alphabet:
Stood alone:	Spoke first word:	Began to read:
Walked alone:	Put 2-3 words together:	Tied shoes:

Education and Occupational History

List all schools the patient has attended:

School & Location (City, State)	Highest Grade level or Degree completed	Comments/Problems

Did/Does this patient receive Early Intervention programming in school? ☐ Yes ☐ No Explain:

Has this patient ever been tested for, or received, special services in school? ☐ Yes ☐ No Explain:

Does the patient like to go to school? ☐ Yes ☐ No Explain:

Strengths/Limitations and Other Information

Strengths/Limitations:

Provide information on the patient's interests/dislikes:

Write any additional comments that may assist in your evaluation and therapy:

Medications

Are you currently taking any medications? ☐ Yes ☐ No ☐ I do not wish to disclose

Medication (Please include ALL taken including over-the-counter, vitamins, nutritional supplements, etc.)	**Dosage/Frequency**	**Route of Administration** (oral, injection, liquid, etc.)	**Managing Physician**