**Child Intake Report**

**Please fill out this biographical background form for your child as completely as possible. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer."**

Referral Date:

Referred By:

Please indicate if you do not wish to periodically receive newsletters or information about groups and services we provide. You can always easily opt out at a future point as well.

 No Yes

**Presenting Problem**

(be as specific as you can: when did it start? How does it affect you?):

Estimate the severity of above problem:

 Mild Moderate Severe

Current Grade:

School:

Academic Performance:

Citizenship and Behavior issues in school:

Parents Marital Status:

If in a relationship how long?

Persons Living at Home (name and relationship):

**Parents/Step-Parents**

(Name/age, occupation, briefly describe their relationship with your child):

Father:

Mother:

Step-Parents:

**Siblings**

(name/age, if dead: age and cause of death & brief statement about the relationship):

1:

2:

3:

4:

5:

Favorite activities, sport, extracurricular activities?

**Pregnancy, Birth, Early Child Development:**

Vaginal/C-Section:

Complications:

Pregnancy (complications):

Substance use and/or medications taken during pregnancy:

Eating and Sleep patterns?

Temperament, frustration management?

Milestones (on time/delayed)?

Medical Doctors (name /phone):

Past/Present Medical Care (major medical problems, surgeries, accidents, falls, illness): Current medical issues:

Past Medical issues and surgeries:

Current Medications (doses and reasons for taking them):

Family Medical History (Describe any illness that runs in the family: cancer, epilepsy, etc):

**Family History of Psychiatric Issues:**

|  |  |
| --- | --- |
| ADD/ADHD (father)ADD/ADHD (mother)AddictionADHDAlcoholism (father)Alcoholism (mother)Alzheimer's (SDAT)Anger ManagementAnorexia/BulimiaAntisocial Features/PDAnxietyBereavementBipolar (mother)Bipolar (father)Borderline Features/PDConduct Problems/Disruptive BehaviorDementia VascularDepressionDepression - BipolarDepression - UnipolarMajor mental illnessDepression NOSDepression/MDD (father)Depression/MDD (mother)Dissociative SymptomsDomestic AbuseDrug AddictionEating Disorder (father)Eating Disorder (mother)GAD (father)GAD (mother)History of neglect | PsychosisPTSD/trauma (father)PTSD/trauma (mother)PTSD/Trauma HistorySchizophrenia/Major Mental IllnessSchizophrenia/Psychotic Dis (father)Schizophrenia/Psychotic Dis (mother)Substance Abuse (father)Substance Abuse (mother)Substance Abuse/AddictionSuicideSuicide/Self-Harming BehaviorsTreatment - Crisis Services (father)Treatment - Inpatient (father)Treatment - Outpatient (father)Treatment - Outpatient (mother)Treatment -Crisis Services (mother)Treatment Inpatient (mother)PanicPanic Disorder (father)Panic Disorder (mother)Personality Disorder (mother)Personality Disorder (father)Phobic Disorder (mother)Phobic Disorder (father)Physical abuseSexual abuseOther (specify in narrative) |

 Other:

Past/Present History of Drug/Alcohol Use/Abuse (AA, NA, treatments):

Past/Present History of Abuse OR Neglect (physical, emotional, sexual):

Suicide Attempt/s or Violent Behavior (describe: ages, reasons, circumstances, how, etc):

Friendships, Community & Spirituality (Describe quality, frequency, activities, etc.):

**Past/Present Psychotherapy or Hospitalizations (specify: month year/s (beginning/end), estimated no. sessions, name, degree, reason for therapy, Indiv/Couple/Family):**

1:

2:

**Current or pending Civil or Criminal Litigation/s, Lawsuits/s or Divorce or Custody Dispute/s? (if you answer Yes, please explain):**

**Disclosure Statement:**

I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part-2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to W Schaffer & Associates. Unless otherwise revoked, this consent expires in 12 months from this date. I understand that once information is disclosed per my authorization, the information may be redisclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations.

Signature: Date: