

**CHRISTIAN WELLNESS CENTER
CHILD/ADOLESCENTS HISTORY/INTAKE FORM**

Name: _____ Date of Appointment: _____

Address: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Parent's Phone # _____ Mobile: _____

Email : _____

Insurance Information:

Insurance Company/HMO: _____ Phone: _____

Member ID# _____ Managed Care Company _____

Claims Address: _____ Phone: _____

Emergency Information

Primary Care Physician: _____ Phone: _____

Name of Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

PRESENTING COMPLAINT

(Please list below the main problems your child is having at this time. You will be asked to give a more detailed description, in person at the initial interview)

What made you decide to bring your child for treatment at this time?

CURRENT FUNCTIONING

Has your child experienced any of the following sleep problems recently?

- | | |
|----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Nightmares/night terrors |
| <input type="checkbox"/> Waking during the night | <input type="checkbox"/> Fears at bedtime |
| <input type="checkbox"/> Waking early | |

Has your child experienced any weight change or problems with appetite recently?

- Decreased appetite: Yes No
- Increased appetite: Yes No
- Lost weight? Yes No Lbs.: _____
- Gained weight? Yes No Lbs.: _____

Unusual eating habits (describe):

Has your child ever:

- Talked about harming self or others? Yes No
Had a specific plan for harming self or others? Yes No
Made an attempt to harm self or others? Yes No
Is this a problem right now (describe): Yes No
-

Please identify any of the following behaviors that would be true about your child:

- | | |
|------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Flexible | <input type="checkbox"/> Outgoing |
| <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Daydreams |
| <input type="checkbox"/> Cooperative | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Excessive fears |
| <input type="checkbox"/> Grasps ideas quickly | <input type="checkbox"/> Engages in stealing |
| <input type="checkbox"/> Hardworking | <input type="checkbox"/> Avoids homework |
| <input type="checkbox"/> Uncooperative | <input type="checkbox"/> Low frustration tolerance |
| <input type="checkbox"/> Difficulty with decision making | <input type="checkbox"/> Lacks motivation |
| <input type="checkbox"/> Lacks self-control | <input type="checkbox"/> Soiling |
| <input type="checkbox"/> Rocking | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> [Unusually aggressive | <input type="checkbox"/> Difficulty with changes in routine |
| <input type="checkbox"/> Creative | <input type="checkbox"/> Needs constant approval/reassurance |
| <input type="checkbox"/> Consistently short attention span | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Gentle/Sensitive |
| <input type="checkbox"/> Unusual sexual behaviors | <input type="checkbox"/> Pessimistic thinking |
| <input type="checkbox"/> Easily influenced by others | <input type="checkbox"/> Underactive |
| <input type="checkbox"/> Self-confident | <input type="checkbox"/> Difficulty telling time |
| <input type="checkbox"/> Frequently tells lies | <input type="checkbox"/> Doesn't seem to understand |
| questions or directions | <input type="checkbox"/> Difficulty making/keeping friends |
| <input type="checkbox"/> Difficulty with organization | <input type="checkbox"/> Frequent, sudden mood changes |
| <input type="checkbox"/> Usually shy or withdrawn | <input type="checkbox"/> Difficulty using numbers |
| <input type="checkbox"/> Changes in sleep patterns | <input type="checkbox"/> Other: _____ |

CHILD SOCIAL/FAMILY HISTORY

1. List all individuals currently living in your household: (use reverse side for more space)

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

2. List other immediate family members not currently living in your household:

Name: _____ Age: _____ Relationship to Child: _____

Name: _____ Age: _____ Relationship to Child: _____

3. List any other significant adults in your child's life:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

4. Marital status of child's biological parents:

Never married [] Yes [] No
Married [] Yes [] No Date(s): _____
Separated [] Yes [] No Date(s): _____
Divorced [] Yes [] No Date(s): _____
Remarried (mother) [] Yes [] No Date(s): _____
Remarried (father) [] Yes [] No Date(s): _____
Additional Information: _____

5. My child has experienced significant loss(es): [] Yes [] No

Please describe: _____

DEVELOPMENTAL HISTORY

Developmental History (developmental milestones met early, late, normal)

Peri-Natal History (details of labor/delivery)

Pre-Natal History (medical problems during pregnancy, mother's use of medications):

PREVIOUS MEDICAL HISTORY

Allergies (adverse reactions to medications/ food/ etc.)

Date of Last Physical Exam: _____

Findings from Exam:

Current Medications (Include prescribed dosages, dates of initial prescription and refills, and name of doctor prescribing medication):

Hospitalization/Surgeries (include dates, complications, adverse reactions to anesthesia, outcomes, etc): _____

Any relevant medical conditions: (diabetes, hypertension, head traumas, cardiac problems, asthma or other breathing problems, cancer, etc.) _____

Past Psychiatric History (Mental Health and Chemical Dependency): _____

Prior Outpatient Therapy (Include previous practitioners, dates of treatment, previous treatment interventions, response to treatment interventions (including response to medications))

Results of recent lab tests and consultation reports: _____

Family Mental Health or Chemical dependency History:

Substance Abuse History (complete for all patients age 12 and over)

substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Others					

Other comments that would be helpful:
