THE RETREAT AT PONTE VEDRA BEACH

CHILD AND ADOLESCENT INTAKE QUESTIONNAIRE - PARENT FORM

General Information:

Child's First Name Middle Last Date of Birth

Primary Home Address City State Zip

Mother's Name Phone

Father's Name Phone

Primary Care Provider Phone

Address City State Zip Fax

Curren School:

School Name Grade/Teacher Principal

Address City State Zip Fax

School Phone Type of classes (Regular/Resource/Honors) Placement (IEP/504)

Address City State Zip Fax

FAMILY INFORMATION

Father's Name: _____ Age: _____ Highest Degree Attained in School:_____

Biological ( ) Adoptive ( ) Step ( ) Foster ( ) Current Occupation:_____

Address and Phone Number, if different from child's:

Mother's Name: _____ Age: _____ Highest Degree Attained in School:_____

Biological ( ) Adoptive ( ) Step ( ) Foster ( ) Current Occupation:_____

Address and Phone Number, if different from child's:

OTHER CHILDREN IN THE HOME:

Name: _____ AGE: _____ GRADE: _____
Name: _____ AGE: _____ GRADE: _____
Name: _____ AGE: _____ GRADE: _____
Name: _____ AGE: _____ GRADE: _____

OTHERS LIVING IN THE HOME: AGE RELATIONSHIP TO YOUR CHILD :

Name: _____ AGE: _____
Relationship to your child: _____
Name: _____ AGE: _____
Relationship to your child: _____
Name: _____ AGE: _____
Relationship to your child: _____

PARENTS' MARITAL STATUS:

Current: Date of Marriage: _____
Status: Married:_____ Separation:_____ Divorce:_____

Prior: Mother married to _____ Date of Marriage: _____
Status: Separation:_____ Divorce:_____

Prior: Father married to _____ Date of Marriage: _____
Status: Separation:_____ Divorce:_____

OTHER TREATING CLINICIANS:

Name: _____Practice: _____
Address _____ _____
Phone # ( ) _____ - _____ Fax # ( ) _____ - _____

Name: _____Practice: _____
Address _____ _____
Phone # ( ) _____ - _____ Fax # ( ) _____ - _____

REFERRED BY:

Name: _____Practice: _____
Address _____ _____
Phone # ( ) _____ - _____ Fax # ( ) _____ - _____

REASON FOR BEING HERE AT THIS TIME, CURRENT PROBLEMS: What brings you here? Please briefly describe your child's current problems starting with the most serious.

ONSET: How long ago did the problems begin? How old was your child? Was there a precipitant? Were there any major stresses happening in the family at the time the problems began?

TREATMENT: What kinds of interventions have been tried? Have you tried medications, seen other therapists, used any "non-traditional" treatments?

RELATIONSHIP STRESSORS: Describe what effects the problems have had on family relationships and family functioning. How does your child get along with each parent and with each brother and/or sister.

SCHOOL STRESSORS: Describe your child's function at school. Are there any problems? What are his/her school-related likes and dislikes?

PEER STRESSORS: Describe how your child gets along with other children. Who are his/her best friends? Have his/her problems affected these relationships?

LIST ALL CURRENT MEDICATIONS, VITAMINS, ADDITIVES AND HERBAL SUPPLEMENTS

Name	Dose	Reason/Purpose	Result/Effect

List side effects, improvements, preferences regarding medications

PAST PSYCHOLOGICAL OR PSYCHIATRIC PROBLEMS

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OTHER PSYCHOLOGICAL OR PSYCHIATRIC PROBLEMS AT ANY OTHER TIME? Please describe other mental health problems and what interventions have been made. What have been the results of these interventions?

Prior Diagnosis:	Age:	Intervention(s):	Result:

PAST MENTAL HEALTH PROVIDERS

Provider	Credentials	Specialty	Dates of Service

PAST AND PRESENT MEDICAL HISTORY

How is your child's general health currently?

ALLERGIES Does your child have any allergies? Please include all medication allergies or food allergies.

Has your child ever had any life threatening allergic reactions?

Allergic to:	Reaction:	Severity:		
		mild	moderate	Life threatening
		mild	moderate	Life threatening
		mild	moderate	Life threatening
		mild	moderate	Life threatening

If your child has a life threatening allergy, do you currently have an epipen or other intervention?

YES/ NO please explain:_____

PRIOR HOSPITAL ADMISSIONS Has your child ever been hospitalized? When and why?

If needed, you can provide more details on the next page

Date of Admission:	Medical	Surgial	Intervention/ Reason for admission:
	Medical	Surgial	
	Medical	Surgial	
	Medical	Surgial	
	Medical	Surgial	

Does your child now, or has your child had a past history of, any medical problems related to the body systems below? Please circle one.

If there is a problem NOW or IN THE PAST please explain in detail below.

Head	Now	In the past	Never
Eyes	Now	In the past	Never

Ears/Nose/Throat	Now	In the past	Never
Respiratory/Lungs	Now	In the past	Never
Chest Pain	Now	In the past	Never
Heart or blood vessels	Now	In the past	Never
Digestive tract	Now	In the past	Never
Liver (hepatitis, etc)	Now	In the past	Never
Genitourinary tract	Now	In the past	Never
Bones	Now	In the past	Never
Muscles	Now	In the past	Never
Hormone system	Now	In the past	Never

NEUROLOGICAL PROBLEMS:

If there is a problem NOW or IN THE PAST please explain in detail below.

Hearing	Now	In the past	Never
Vision	Now	In the past	Never
Head Trauma	Now	In the past	Never
Severe headaches	Now	In the past	Never
Seizures	Now	In the past	Never
Seizures only with high fevers	Now	In the past	Never
Encephalitis	Now	In the past	Never
Meningitis	Now	In the past	Never
Loss of consciousness or blackouts	Now	In the past	Never
Fainting	Now	In the past	Never
Trance-like episodes	Now	In the past	Never
Hormone system	Now	In the past	Never
Chronic dizziness	Now	In the past	Never

Double vision	Now	In the past	Never
Tremor	Now	In the past	Never
Unexplained poor coordination	Now	In the past	Never
Trouble walking	Now	In the past	Never
Memory problems	Now	In the past	Never

Please describe your child's current **sleep habits**:

	Bedtime:	
	Wake-up time:	

Please describe your child's current **appetite habits**:

	Picky eater	Grazer
	No problems	3 meals + snacks

Does your child *currently or* has your child *ever* had any serious medical illnesses? YES / NO

If Yes; Please describe all illnesses and their treatments:

Has your child ever had any serious injuries? YES / NO

If Yes; Please include *all* head injuries, concussions, losses of consciousness. Describe all injuries and their treatments. Did any require hospitalization?

Has your child ever had surgery? YES / NO

If Yes; Please describe the surgery. Include the date and outcome:

OTHER HEALTH HISTORY:

Age of first menstrual period:		Number of days in cycle:		
Date of last period:		Cycles are:	Regular	Irregular
Any difficulties related to menstrual periods:	YES / NO	If Yes; explain:		
On Birth Control:	YES / NO	If Yes; explain:		

DATING HISTORY

Currently dating?	YES / NO	If Yes; specify:	Girlfriend	Boyfriend
Current Sexual activity:	YES / NO	If Yes, number of partners:		
Use of protection:	YES / NO	If Yes; explain:		
Recent Breakup:	YES / NO	If Yes; explain:		
Other Dating information:				

SUBSTANCE USE HISTORY

Has your child ever tried, or does your child currently use, any chemical substances or had medical of legal issues related to substance use? YES / NO

If Yes; Please explain:

EXPOSURE TO TOXIC OR DANGEROUS CHEMICALS OR MATERIALS: YES / NO

If Yes; Circle substance and please explain below including date/age of exposure:

Insulation	Asbestos	Fumes
Lead	Mercury	Plastics
Metals	Solvents	Dyes
Chemicals	Other Materials	

Has your child traveled to a foreign country in the last 10 years? Yes/No

Where?_____ Date(s)of travel?_____

Were their immunizations up to date? YES/ NO

Are your child's immunizations currently up to date? YES/ NO

IS THERE ANYTHING ELSE YOUR PROVIDER SHOULD KNOW ABOUT YOUR CHILD'S MEDICAL HISTORY?

FAMILY HISTORY

Please report general and mental illness, addiction, neurological disorder, breathing or cardiac illness, early death, autoimmune disorders. Please indicate depression, bipolar disorder, schizophrenia, anxiety, eating disorder, autism, personality disorder, ADHD, Learning disorders specifically.

Father	
Mother	
Brother	
Sister	
Paternal Grandparents	
Maternal Grandparents	
Aunts/Uncles/Cousins	
Other	

DOES ANY FAMILY MEMBER HAVE ANY OTHER MEDICAL ILLNESS OR DISORDER, INCLUDING HEREDITARY DISORDERS, YOUR PROVIDER SHOULD KNOW ABOUT? YES / NO

If Yes; Please explain:

Has any family member ever taken any psychiatric or mental health medication? YES / NO

If Yes; Please explain who it was and the medication purpose, effect, and/or result:

Has any family member ever had a psychiatric hospitalization, ECT (electroconvulsive therapy) or "shock treatment", suicide attempts? YES / NO If Yes; Please explain:

Has any family member ever been arrested or incarcerated? YES / NO If Yes; Please explain:

CHILD'S DEVELOPMENTAL HISTORY

Did your child's biological mother have any difficulties or complications during her pregnancy with this child? YES / NO If Yes; Please explain:

Any Serious Infection like Measles/German measles, Toxoplasmosis, Syphillis, Herpes, Flu or other virus? YES / NO If Yes; Please explain:

Was this pregnancy considered "high risk" Maternal age over 40 years or under 20 years, or advanced paternal age? YES / NO If Yes; Please explain:

Was the pregnancy shorter than 38 weeks or longer than 42 weeks? YES / NO If Yes; Please explain:

Were any medications prescribed during this pregnancy?YES / NO
If "yes" which medications and during which trimester?

During pregnancy, did your child's biological mother engage in any of the following?
Smoking tobacco? YES/ NO If "yes", how much and during which trimester?

Drinking alcohol? YES / NO If "yes", how much and during which trimester?

Any drug use (i.e. marijuana, cocaine, ecstasy, etc.)? YES/ NO
If "yes", which drugs and during which trimester?

Did your child have complications at birth related to exposure to medications of substances while in utero? YES / NO If Yes; Please explain:

PREGNANCY-RELATED

Was this pregnancy planned?	YES	NO
Was there a preference for boy or girl?		
Was this child the biological mother's first pregnancy?	YES	NO
If "NO" to First Pregnancy: How many prior live births? _____ How many prior miscarriages?_____		
Any prior terminated Pregnancies?	YES	NO
If "YES" How many prior terminated pregnancies? _____		

NEONATAL PERIOD AND INFANCY

Was this baby in the neonatal ICU?	YES	NO
Did the baby remain in the hospital after the birth mother went home?	YES	NO
Infancy: Was there anything unusual, different or difficult about this child during the first 12 months of life?	YES	NO
Had to switch formulas 3 times or more?	YES	NO
Cried day and night, couldn't be consoled/Colicky?	YES	NO
Too quiet or "too good" ?	YES	NO
Stiffened up when held, or pushed you away?	YES	NO
Floppy or limp when held, or didn't cuddle with you?	YES	NO
Hard to care for?	YES	NO
Other concerns?	YES	NO

DEVELOPMENTAL MILESTONES	**Age**	**Any Concerns?**
Social Smile		
Roll over		
Sit without support		
Crawl		
Stranger anxiety		

Waving, peek-a-boo, and Playing patty cake		
Standing		
Walking		
Pretending in Play		
Tricycle/Bicycle		
Cooperating with others		

Feeding, Toileting, Bathing	**Age**	**Any Concerns?**
Bottle Feeding		
Drinking from a Cup		
Eating Solids		
Using Spoon Alone		
Helping to Dress		
Dressing Alone		
Staying Dry all Night		
Staying Dry all Day		
Use toilet for urine		
Use toilet for stool		

Speech and Language	**Age**	**Any Concerns?**
First Sounds		
Single Words		
2 Word Phrases		

Using Sentences		
Understood By Strangers		
Speech Impediment?		
Speech Therapy?		
Repeating words or phrases?		
Quoting excessively?		
Correct use of Pronouns		
Initiates Conversations?		
Talks about topics other than primary interest?		

Has anyone ever suggested your child might have a developmental delay?

Has anyone ever suggested your child might intellectual disability?

Has your child, or does your child, do any of the following; Body rocking, Head banging, Hand flapping, Toe walking, Make repetitive nonsense sounds when old enough to speak?

IS THERE ANYTHING ELSE YOUR PROVIDER SHOULD KNOW ABOUT YOUR CHILD'S SOCIAL HISTORY?

SCHOOL HISTORY

WHICH SCHOOLS HAS YOUR CHILD ATTENDED?

Name of School	Grades Attended	Dates	Reason for Leaving	Type of Class

Describe your child's attitude toward school.

Describe your child's behavior in school.	
Has your child ever refused to go to school? If "yes", please explain.	
Which are his/her best subjects?	
Which are his/her favorite subjects?	
Which are his/her worst subjects?	
Which are his/her least favorite subjects?	
Have your child's grades changed over time? If "yes", please explain.	
Has your child been tested for Learning Disabilities? If "yes", please describe the results.	
Has your child been held back or skipped a grade? Please explain.	

IS THERE ANYTHING ELSE YOUR PROVIDER SHOULD KNOW ABOUT YOUR CHILD'S SCHOOL HISTORY?

FAMILY SOCIAL HISTORY

Have there been any recent stresses in the family? YES / NO If Yes; Please explain:

Has anyone recently left the family or died? YES / NO If Yes; Please explain:

Has anyone recently joined the family? YES / NO If Yes; Please explain:

Have there been any recent employment changes or job losses? YES / NO If Yes; Please explain:

Have there been any recent financial changes (good or bad)? YES / NO If Yes; Please explain:

How many times has your family moved during your child's lifetime? _____ / N/A

Please explain your moves and reasons for moving:

How did your child adapt to moving:

IS THERE ANYTHING ELSE YOUR PROVIDER SHOULD KNOW ABOUT YOUR FAMILY?