Children's Hospital New Orleans
LCMC Health

Outpatient Psychiatry Intake Questionnaire

Please complete and bring this form to your child's first appointment
Your thoughtfulness in answering these questions helps us understand your child

Date:

Person completing form: Relationship to patient:

Patient's Name:

(Last) (First) (Middle)

Patient's Date of Birth: Patient's Age: Sex assigned at birth: ☐Male ☐Female ☐Intersex

Patient's Gender:

Patient's Current Address:

Home Phone Number: Cell Phone Number:

Parent/Legal Guardian Name: Age:

Current Address:

Occupation: Education:

Email Address: Preferred Phone Number:

Parent/Legal Guardian Name: Age:

Current Address:

Occupation: Education:

Email Address: Preferred Phone Number:

Step/Foster Parent Name: Age:

Current Address:

Occupation: Education:

Email Address: Preferred Phone Number:

Step/Foster Parent Name: Age:

Current Address:

Occupation: Education:

Email Address: Preferred Phone Number:

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PROBLEM HISTORY

Briefly describe concerns you have about your child and why are you seeking help?

Please select the problems your child **currently** demonstrates:

☐Hyperactivity
☐Impulsivity
☐Poor attention span/difficulty concentrating
☐Disorganized/forgetful
☐Difficulty finishing tasks/projects

☐Aggressive behavior at home
☐Aggressive behavior at school
☐Temper outbursts
☐Irritability

☐Feeling sad or hopeless
☐Change in appetite
☐Difficulty falling asleep or staying asleep
☐Nightmares/night terrors
☐Thoughts of suicide
☐Often thinking about death, loss
☐Crying often

☐Snoring or difficulty breathing while asleep

☐Seeing, hearing, or feeling things that are not real

☐Feeling anxious/nervous/worried frequently
☐Having panic attacks
☐Social withdrawals

☐Tics or other involuntary movements
☐Pulling out hair or eyelashes

☐Picky eating
☐Weight loss or concern with body image
☐Binge eating/purging or restricting diet

☐Bed wetting
☐Daytime toileting accidents

☐Very rigid adherence to routine
☐Problems with transitioning between activities
☐Having few friends

☐Being bullied or cyberbullied
☐Victim of physical, sexual abuse (see last page)
☐Substance Use (see last page)
☐Other problems

Please describe three of your child's strengths:

Please describe any dangerous activities your child has been exposed to or engaged in:

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Treatment History

☐ADD/ADHD
☐Asperger Disorder
☐Autism
☐Bipolar Disorder
☐Depression

☐Eating Disorder
☐Encopresis (bowel accident)
☐Enuresis (urinary accident)
☐Psychosis/Schizophrenia

☐Developmental Delay
☐Reactive Attachment

☐Reading Disorder (Dyslexia)
☐Math Disorder
☐Learning Disorder

☐Behavior Disorders
☐Substance Abuse
☐Oppositional Defiant Disorder
☐Conduct Disorder

☐Fire Setting

☐Anxiety Disorder
☐Adjustment Disorder
☐Phobias
☐Panic Attacks

☐Obsessive Compulsive Disorder
☐Tourette's syndrome/tics
☐Trichotillomania (hair pulling)
☐Other:

Has your child ever attempted to harm him/herself or attempted suicide? ☐Yes ☐No
If yes, please describe:

Current Therapist Name:
Address:
Phone Number:

Other professionals involved in care
Name:
Address:
Phone Number:

Has your child ever been hospitalized for a mental health/behavioral problem? ☐Yes ☐No

If yes, please list the date of treatment, facility, location, and chief complaint below:

Dates of Treatment i.e., 11/01/2018-11/05/2018	**Facility** i.e., Hospital/residential	**Problem Addressed** i.e., Depression, etc.

Please list any past **outpatient** mental health treatments

Dates of Treatment	**Psychiatrist/Therapist/Counselor**	**Location**	**Reason for Treatment & Response to Treatment**

Has your child ever had a Neuropsychological/Psychological evaluation? Yes No

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Date:
Name of Psychologist:
Location
Reason for testing:

Has your child ever received physical or occupational therapy treatment or evaluation? Yes No
Date:
Name of provider:
Location
Reason for evaluation/treatment:

Has your child ever received speech-language treatment or evaluation? Yes No
Date:
Name of provider:
Location
Reason for evaluation/treatment:

Medical History

Name of primary care physician:
Address:
Phone Number:

List any allergies to medication or foods:

List current medical problems for which your child is being treated:

List any surgeries

List any hospitalizations for medical illness

Has your child ever had any of the following conditions? (Check all that apply)

Head, ears, nose, throat
☐Visual problems/glasses
☐Frequent nose bleeds
☐Dental problems
☐Frequent sore throats
☐Frequent ear infections
☐Trouble hearing

Heart
☐Palpitations/Rapid Heart Rate
☐Heart Murmur
☐Poor exercise tolerance
☐Dizzy spells or blackout lungs
☐Chronic cough
☐Asthma/wheezing
☐Sleep apnea
☐Snoring

Stomach and intestines
☐Constipation/diarrhea
☐Leakage of stool
☐Nausea/vomiting
☐Bloating/indigestion
☐Frequent "heartburn"
☐Liver problems
☐Frequent fatigue

☐Problems with appetite
☐Major weight loss or weight gain
☐Difficulties walking, running, playing
☐Frequent fevers, illnesses

Musculoskeletal
☐Broken bones
☐Torn ligaments or joint problems
☐Painful joints or muscles

Neurologic
☐Tremors
☐Seizures
☐Tics/Involuntary movements
☐Headaches
☐Tinnitus (ringing in ears)
☐Head injuries/concussions

Skin
☐Skin rashes
☐Eczema
☐Area of skin discoloration/birthmarks
☐Burns

Kidneys and urinary tract
☐Kidney, bladder, or urethral problems
☐Enuresis (urinary accidents)
☐Bed wetting
☐Frequent urination
☐Frequent urinary tract infections
☐Started menstrual periods? What age?

Endocrine
☐Diabetes
☐Frequent thirst
☐Often needing to eat
☐Difficulty tolerating cold or hot conditions

Blood/immune system
☐Easy bruising
☐Blood clotting disorder
☐Lumps under arms, below neck, in thigh areas
☐Comprised immune system/frequent infections
☐Allergies

Does your child presently take medications including over the counter or naturopathic medicine?

Medication	Dosage	Reason for taking & noted benefits	Date (Started/Stopped)	Prescribed by

Family History

Of the child's biologic (blood) relatives is there any history of the following?
*Please mark with **M**=mother, **F**=father, **S**=sister, **B**=brother, **GM**= grandmother, **GF**= grandfather, **U**=uncle, **A**=aunt, **C**=cousin*

Problem/Diagnosis	Relationship to Child
Depression	
Anxiety or panic symptoms	
Obsessive compulsive disorder	
Bipolar/manic depression	
Schizophrenia/psychosis	
Attention deficit/hyperactivity disorder	
Tics/Tourette's	

Criminal behavior	
Attempted/completed suicide	
Psychiatric Hospitalization	
Substance abuse	
Autism/Developmental delay	
Learning disorders	
Thyroid illness	
Seizures	
Migraine	
Sudden cardiac death/rhythm problem	
Kidney disease	
Liver disease	
Cancer	

Pregnancy and Birth History

How many weeks did the pregnancy last (normal is 38-42 weeks)?

☐Normal vaginal delivery or ☐C-section Birth Weight: lbs oz. Birth Length: inches
Apgar scores (if known): First: Second:

Please list any medications taken during pregnancy

Medication	Months taken (of 9)	Reason for taking

Please list any substance use or toxic exposures during pregnancy (alcohol, tobacco, etc.)

Medication	Months taken (of 9)

List any illnesses during pregnancy:

List any difficulties your child had during or immediately after delivery:

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Select any difficulties your child exhibited during infancy			**Developmental Milestones**	
Difficult to hold, cuddle, or comfort	☐Yes	☐No	Sit up alone	Age:
Colic	☐Yes	☐No	Walk alone	Age:
Restless of irritable	☐Yes	☐No	Spoke first words	Age:
Problems with sleep	☐Yes	☐No	Spoke in sentences	Age:
Problems with nursing or feeding	☐Yes	☐No	Bladder training complete	Age:
Health problems as infants	☐Yes	☐No	Bowel training complete	Age:
Seizures during infancy	☐Yes	☐No	If yes to any of the above, please describe	
Other	☐Yes	☐No		

Developmental or Behavioral Concerns

Did your child have any of these problems and at what age did it first occur?	**Ages 1-18 months**	**Ages 18 months to 3 years**	**Ages 3-5**
High fevers			
Chronic ear infection/tubes placed			
Heartburn or reflux			
Poor weight gain or weight loss			
Difficulty playing with other children			
Rocking, spinning, head banging, hand flapping			
Walking on tip toes or poor coordination			
Restless, irritable, difficulty calming self			
Nightmares, other sleep problems			
Thumb sucking			
Bedwetting			
Difficulty being cuddled, held, or comforted			

Child's cultural identity:

What spiritual or faith concerns need to be considered?

Language spoken at home: ☐English ☐Other: _____

Is child in foster care? ☐Yes ☐No

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Is child adopted? ☐Yes ☐No If yes, at what age?

Does family or child know birth family? ☐Yes ☐No

Has there been any adjustment issues for family or patient related to adoption?

Are there any events in caregiver/parent's life that influence parenting style?

Who lives in the child's primary home?

Name	Age	Relationship to patient

Close family members and other supportive individuals not living in the home?

Name	Age	Relationship to patient

Current School

Name: Child's current grade:

Handedness: ☐Left ☐Right ☐Both (Ambidextrous)

School Experience/Learning Experience			
Name of Schools Attended	**Grades/Teachers' Reports**	**Academic Concerns**	**Behavioral/Social Concern**
Preschool			
Kindergarten			
Elementary			
Middle/Junior High			
High School			

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Did/Does your child receive early intervention services? ☐Yes ☐No

To the best of your knowledge, at what grade level is your child currently performing?

Reading: Spelling: Math: Writing:

Has your child ever been held back or has retention ever been suggested? ☐Yes ☐No

Has your child ever received Special Education services or received accommodations through a 504 plan or IEP (Individualized Education Plan) and why? ☐Yes ☐No

☐Autism Spectrum Disorder
☐Communication Disorder
☐Hearing or vision impaired
☐Learning disability
☐Math, reading or writing problems
☐Traumatic brain injury
☐Intellectual disability
☐Physical handicap
☐Other health impaired
☐Behavior problems
☐Other developmental delay

What was child's IEP or 504 plan **most recently** reviewed, and what were the goals? (Attach if possible)

Does your child receive any of the following in school?

Adapted physical education

Occupational therapy

Physical therapy

Speech therapy

Counseling

Tutoring

Has a classroom teacher reported any of the problems below? (If so, in what grade did it start)	
Attention/concentration/distractible/hyperactive	Grade:
Behavior problems or aggression	Grade:
Reading, Spelling, Math, or handwriting problems	Grade:
Forgetful, loses papers, difficulty following directions	Grade:
Difficulty getting along with other kids/few friends	Grade:
Anxious, sad, withdrawn	Grade:
Sleepiness	Grade:

Extra-curricular activities at school (sports, clubs) or after school:

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Does your child have friends? ☐Yes ☐No older, younger, or same age?

Does your child have a best friend? ☐Yes ☐No Name:

How does your child interact with friends?

☐Acts bossy ☐Disinterested in others ☐Withdrawn

☐Initiating play ☐Make new friends ☐Shares

☐Group play ☐Keep old friends ☐Compromises

☐Accepted by kids ☐Bullies others ☐Individual play

Does your child have any of the following in his/her bedroom?

☐TV ☒Computer ☐Cellphone ☐Landline phone

On average, how much time does your child spend every day doing the following activities?

Activity	Average Hours Daily	Any problems as a consequence?
Favorite video games		
Favorite television show		
Frequent internet website		
Reading favorite book		
Engaging in favorite activity		

Abuse or Maltreatment

Has your child been the victim of sexual abuse, physical abuse, or bullying? Please describe event (s) and if there were legal consequences.

Other traumatic events

Substance Abuse	**Age Started**	**Current Use**	**Legal Consequences**	**Previous evaluation or treatmen**
Alcohol		☐Yes ☐No		
Marijuana		☐Yes ☐No		
Opiates, Heroin		☐Yes ☐No		
Cocaine		☐Yes ☐No		
Methamphetamine		☐Yes ☐No		

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Substance Abuse	Age Started	Current Use	Legal Consequences	Previous evaluation or treatment
Hallucinogens (LSD, mushrooms)		☐Yes ☐No		
MDMA (ecstasy/molly)		☐Yes ☐No		
Bath Salts (Synthetic cathinone)		☐Yes ☐No		
K2/Spice (Synthetic Marijuana)		☐Yes ☐No		
Inhalants		☐Yes ☐No		
Prescription drugs, cold medicine		☐Yes ☐No		
Salvia		☐Yes ☐No		
Club drugs (RGB, Rohypnol, Ketamine)		☐Yes ☐No		
Tobacco		☐Yes ☐No		
Anabolic steroids (testosterone)		☐Yes ☐No		

Is there any other issue you want to convey about your child?