PEDIATRIC ASSOCIATES
OF MT. CARMEL, INC.

Psychiatry Intake Form

Child's Full Name_____Today's Date_____
Child's Date of Birth_____Gender_____

Who is completing this form and what is your relationship to the child?

_____

Who are the child's legal guardians?

_____

Who lives at home with the child, including other children?

_____

Is the child adopted? Yes No

What are the problem(s) for which you are seeking help?

1._____
2._____
3._____

What mental health conditions has your child previously been diagnosed with?

_____

Has your child ever stayed overnight in the hospital for mental health reasons? Yes No
Has your child ever been to the emergency room for mental health reasons? Yes No

Has your child ever been in therapy or counseling for mental health concerns? Yes No
Current Therapist/Counselor _____
Current Therapist/Counselor Phone or Email _____

Has your child ever had testing completed by a psychologist or through their school, including IQ testing, achievement testing, or testing for autism spectrum disorder? Yes No
If so, where was the testing done? _____

Has your child received physical therapy, occupational therapy, or speech therapy? Yes No

List all <u>current</u> prescriptions, other medications, and supplements your child is taking:

Medication Name	Dose	Estimated Start Date

If your child has been prescribed medication for mental health concerns from a doctor outside of Pediatric Associates of Mt. Carmel, please provide their contact information here:

_____

List any past medications that your child has tried for behavioral or mental health concerns:

Medication Name	Dose	Estimated Dates Taken

What school does your child attend? _____

Current Grade: _____ Has your child ever repeated a grade? Yes No

Does your child have an IEP, 504 plan, or any other extra help at school? Yes No

If we have questions about how your child is doing at school, who should we contact?

_____

Does your child have concerns about their sexual orientation or gender identity? Yes No

As far as you are aware, has your child ever used nicotine products (including vaping), alcohol, or illicit drugs (including marijuana)? Yes No

Has anyone in your family been diagnosed with or treated for mental health conditions or substance abuse? Examples include depression, anxiety, ADHD or ADD, autism spectrum disorder, learning disabilities, bipolar disorder, psychosis, schizophrenia, suicide attempts, alcoholism, or drug use. Yes No

If yes, please explain:

_____

_____

Has your child ever been arrested or otherwise involved with the legal system? Yes No

Are there any weapons or guns in your home? Yes No

In the past, has your child ever:

- Been neglected Yes No
- Been physically abused Yes No
- Been emotionally or verbally abused Yes No
- Been sexually abused Yes No
- Been bullied Yes No
- Witnessed domestic violence Yes No

I grant permission for Pediatric Associates of Mt. Carmel to contact any of the persons listed above to obtain information about my child's mental health history. Yes No

I grant permission for Pediatric Associates of Mt. Carmel to maintain contact with my child's therapist and school if necessary to provide the best possible care for my child. Yes No

Guardian's Signature: _____

Printed Name: _____ Date: _____