Psychiatric Assessment Intake

Today's Date:

Child's Name			
Date of Birth (dd-Mon-yyyy)		Gender	Age
Caregiver/Guardian/Parent Name		Personal Health Number	
Parent/Guardian Phone #	Family Doctor	Therapist	
Home Address (with Postal Code)			
School Name and Grade			

Parents Living **With** Child/Teen			
Father's name	bio step foster	Age	Occupation
Mother's Name	bio step foster	Age	Occupation
Parents Living **Apart** From Child/Teen			
Father's name	bio step foster	Age	Occupation
Mother's Name	bio step foster	Age	Occupation

List all other people (including children/teens) who presently live in your home. If siblings please specify if they are biological, adopted, half, step, or foster

Name	Sex (M/F)	Age	Relationship to child/teen	Occupation or grade

Childhood Development

1. How old was your child when they started walking? _____
2. At what age did your child start talking? _____
3. Did your child have many friends as a younger child? _____
4. Does your child have close friends now? _____

Medical History

Past Surgeries or Hospitalizations: list procedure/reason for admission and age it occurred

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Has your child experienced any abuse (Physical, Emotional, Sexual: Please describe in detail including age and length of time in which it occurred)

Family History-Please Check all that apply even if not formally diagnosed

	Please identify who in the family (if anyone) has experienced any of the following:
Depression	
Bipolar Disorder	
Schizophrenia	
ADHD	
Concentration Problems	
Hyperactivity	
Anger Outbursts	
Severe Agitation	
Nervous Breakdown	
Anxiety	
Panic Attacks	
Phobias	
Obsessive Worrying	
Compulsions	
Attempted Suicides	
Completed Suicides	
Alcoholism	
Drug Abuse/Use	
Abuse as an Abuser or Victim	

During Pregnancy did mom:

Smoke _____ Drink Alcohol _____ Take any prescription medications _____

Illicit Drugs _____ Experience excessive stress_____

Psychiatric History

Psychiatric Hospitalizations (dates, locations, reason for admission, and length of stay):

Past Psychotherapy/Counselling (dates, length of time, and focus of treatment):

Previous treatment by a Psychiatrist (dates, lengths of time, and focus of treatment):

Current Psychiatric Involvement:

Any current Psychotherapy/Counselling (Name, dates, length of time, and focus of treatment)

Any Current treatment by a Psychiatrist (Name, dates, length of time, and focus of treatment)

Has your child experienced or expressed any suicidal ideations either in the past or currently?
Has your child attempted suicide in the past? Please describe

Do you suspect/know if your child is using any alcohol, marijuana or any other substances? Please describe:

Medications

Current Medications and Dose (length of time, purpose, results, side effects? who prescribed the medication?)

Current Vitamins/ Supplements

Past Medications and Dose (length of time, purpose, results, side effects? who prescribed the medication?)

School and Extracurricular

Does your child struggle academically or socially in school: Please describe

What are your child's hobbies and likes?

Has your child done any formal Psycho-Educational Assessment through school? If so were there any areas of concern identified?

Stressful Events

Please describe any stressful events your child may have experienced, witnessed, or is currently struggling with (bullying, divorce, moves etc)

Presenting Problem

In your own words summarize what is the current issue that has led you/your child to seek psychiatric assistance.

Purpose of Visit

Please describe your goals for this assessment, what are you hoping this assessment will achieve?

Behavior Check List			
Have you noticed your child / teen frequently behaves in any of the following ways?	**Always**	**Sometimes**	**Never**
Fidgets with hands, feet or squirms in seat			
Has difficulty remaining seated when required to do so			
Easily distracted by a lot going on			
Has difficulty awaiting his / her turn in games or group situations			
Blurts out answers to questions before they have been completed			
Has problems following through with instructions *(usually not due to opposition or failure to comprehend)*			
Has difficulty paying attention during tasks or play activities			
Shifts from one incomplete activity to another			
Has difficulty playing quietly			
Often talks excessively			
Interrupts or intrudes on others *(often not purposeful or planned but impulsive)*			
Does not appear to listen to what is being said			
Loses things necessary for tasks or activities at home			
Boundless energy and poor judgement			
Impulsivity *(poor self-control)*			
History of temper tantrums			
Does things over and over *(i.e. hand washing, touching certain objects)*			
Frustrates easily			
Sloppy table manners			
Sudden outbursts of physical abuse towards others			
Acts like he / she is driven by a motor			
Wears out shoes more frequently than siblings			
Excessive number of accidents			
Doesn’t seem to learn from experience			
Poor memory			
Described as a “different child or teen”			
Harms or teases animals			
Plays with or has fascination with fire			
Bullies others			

To be Completed during Assessment with Psychiatrist and Child/Teen

Drug and Alcohol Use/History

Cigarettes/Tobacco/Vaping:

1. Do you currently smoke, chew or vape? YES____ NO____

If yes: Number of years ____ Number of packs/day ____ Last time using ____

If no: Have you used these products in the past? YES____ NO____

Caffeine:

1. Do you drink coffee or other caffeinated drinks? YES ____NO____

If yes: Number of cups/beverages per day ____ Type of beverage _____

Alcohol:

1. Do you drink alcohol currently or have you within the last year? YES____ NO____

If yes: How many times per week? ____ Type of Beverage _____

Average amount consumed per week ____ How long have you been drinking?

____

2. Have you consumed alcohol in the past? YES ____ NO ____

   How long ago? _____

Drug Use:

1. Do you currently use any drugs or illicit substances? YES ____ NO ____

If yes: Type of drug_____

How much/How Often/How long? _____

2. Have you used drugs in the past? YES ____ NO ____

If yes: Type of drug_____

How much/How Often/How long? _____

How long since last use?_____ Do you participate in any programs for continued sobriety? YES____ NO ____ If Yes, which program_____

Risk Assessment

	YES	NO
Do you have thoughts of harming yourself		
Do you have a plan for how you would harm yourself		
Have you attempted to harm yourself in the past		
Do you have thoughts of harming someone else		
Have you assaulted or threatened anyone recently		
Have you ever been in trouble because of your temper/violence		
Does drinking/using drugs ever lead you to become violent		
Do you own a gun or lethal weapon		
Have you ever considered/planned to harm yourself or others with this gun or lethal weapon		