1900 Byrd Ave Suite 200
Richmond VA 23230
(804) 592-6311

Child Intake Form

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. Please bring this form to your first appointment. *For Psychiatric Appointments, please bring any available medical records and prescription history to your first appointment.*

Name: _____
(Last) (First) (Middle)

Birth Date: _____/_____/_____ Age: _____ Gender: _____ Nickname: _____

Name of parent/legal guardian:

_____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number)

_____ Home Phone: ( ) _____ Messages ok? ☐Yes ☐No
(City/State/Zip)

Cell/Other Phone: ( ) _____ Messages ok? ☐Yes ☐No

Guardian's Email: _____ May we email you? ☐Yes ☐No

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: ( ) _____

Referred By: _____

Has your child previously received any type of mental health services (therapy, psychiatric care, etc.)?
☐No
☐Yes, previous therapist/psychiatric provider: _____

Is your child currently taking any prescribed medication?
☐No
☐Yes, please list: _____
_____

Has your child ever been prescribed psychiatric medication?
☐No
☐Yes, please list and include dates:
_____
_____

General Health & Mental Health Information:

1. How would you rate your child's current physical health (please circle one):

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems your child is currently experiencing: _____

_____

2. How would you rate your child's current sleeping habits (please circle one):

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems your child is currently experiencing: _____

_____

3. How many times per week does your child generally exercise: _____

What types of exercise does your child participate in:
_____

4. Please list any difficulties your child may experience with appetite or eating patterns:

_____

5. Is your child currently experiencing overwhelming sadness, grief, or depression?
☐No
☐Yes, if so, for approximately how long? _____

6. Is your child currently experiencing anxiety, panic attacks, or have any phobias?
☐No
☐Yes, if so, when did they begin experiencing this? _____

7. Is your child currently experiencing any chronic pain?
☐No
☐Yes, please describe: _____

8. Has your child engaged in any alcohol or drug use to your knowledge? ☐No ☐Yes ☐Unsure
If yes, please describe: _____

9. How often does your child exhibit temper tantrums or behavioral issues? ☐Daily ☐Weekly ☐Monthly ☐Infrequently
☐Never Describe: _____
_____

10. What significant life changes or stressful events has your child experienced recently:
_____
_____
_____

Family Mental Health History:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no ……	
Anxiety	yes/no ……	
Depression	yes/no ……	
Domestic Violence	yes/no ……	
Eating Disorders	yes/no ……	
Obesity	yes/no ……	
Obsessive Compulsive Disorder	yes/no ……	
Schizophrenia	yes/no ……	
Suicide Attempts	yes/no ……	

Additional Information:

1. How would you rate the current stress level in the family home? Please circle one:

Very Stressful Stressful Neutral Stress-free

If stressful, what contributes mostly to the stress?
_____

2. School Information:
Name of School: _____
Grade: _____

How would you rate your child's school performance? Please circle one for each:

Academics (grades in school): Poor Unsatisfactory Satisfactory Good Very Good

Behavior in school: Poor Unsatisfactory Satisfactory Good Very Good

3. Is your family spiritual or religious? ☐No ☐Yes, if so, describe your faith or belief:

_____

4. What do you consider to be some of your child's strengths?

_____
_____
_____

5. What do you consider to be some of your child's weaknesses?
_____
_____
_____

6. What would you like your child to accomplish out of their time in therapy/psychiatric services?
_____
_____
_____

7. What additional information would you like your provider to know about your child?
_____
_____
_____

For Psychiatric Appointments Only:

1. Do you have a preferred pharmacy? ☐No ☐Yes

_____
(Pharmacy Name) (Location)

2. Does your child have a Pediatrician? ☐No ☐Yes

_____
(Provider/Practice Name) (Phone Number)

3. Does your child have any allergies (food, medical/drug, environmental)? ☐No ☐Yes, if so, describe:

_____