Dr Sadek's Psychiatric Child/Adolescent Intake Form

Date: _____ Your Child's name: _____
Parents/Guardian Name(s):_____
Date of Birth: _____ Health Card#: _____ Sex: _____
Phone: _____ Cell:_____
Address:
_____
_____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today:
_____
_____
Please list who lives with your child:
_____
Does your child have any previous diagnosis?
_____

CHIEF COMPLAINTS

Please describe the top three problems your child is troubled with right now:
_____
_____

Over the last 2 weeks, how often has your child been troubled by any of the following problems?

Please Check	Few days or Never	More than half the days	Nearly Everyday
Little interest or pleasure in things child usually enjoyed			
Feeling low, depressed, or hopeless			
Trouble falling or staying asleep			
Sleeping too much			
Feeling tired, fatigued			
Poor appetite			
Overeating			
Poor ability to think or concentrate			
Moving or speaking so slowly			
Fidgety or restless			
Active thoughts of death, wishing or trying to die			

Please answer if your child has had any of the following:

	YES	NO		YES	NO
worried excessively			Difficulty communicating with others		
worries present most days			have a odd speech		

Very nervous or unable to relax most of the time			wet himself/herself during the day		
have unexplained aches and pains			problems with sleep		
have a language delay			soil himself/herself		
experienced any strong fears			a severe temper outbursts that happen frequently either verbally and/or physically		
makes poor eye contact or uses unusual body language			Harm himself/herself in the past		
always fails to make friends			assaulted or threatened anyone recently		
unable to share his/her enjoyment with others			Is there a gun or a lethal weapon where your child lives		

Please answer how often the following happens to your child (ADHD):

	Rarely or Never	Sometimes	Often	Very Often
Fails to give close attention to details or makes careless mistakes in school work or tasks				
Has difficulty sustaining attention in tasks or play activities				
Does not seem to listen when spoken to directly				
Does not follow through on instructions and fails to finish school work, chores, or duties				
Has difficulty organizing tasks and activities				
Avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort				
Loses things necessary for activities (e.g., toys, school assignments, pencils, or books)				
Is distracted by extraneous stimuli				
Is forgetful in daily activities				
Has difficulty awaiting turn				
Fidgets with hands or feet or squirms in seat Leaves seat in				

classroom				
Runs about or climbs excessively in situations in which it is inappropriate				
Has difficulty playing or engaging in leisure activities quietly				
Is “on the go” or often acts as if “driven by a motor				
Talks excessively				
Blurts out answers before questions have been completed				

Please answer if your child has had any of the following:

	YES	NO		YES	NO
Often loses temper			Often argues with adults		
Often actively defies or refuses adult requests or rules			Often deliberately does things that annoy other people		
Often blames others for his/her mistakes or misbehaviour			Often touchy or easily annoyed by others		
Often is angry and resentful			Often is spiteful		
Bully, threaten, or intimidate others			Initiate physical fights		
Have used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)			Have been physically cruel to people		
Have been physically cruel to animals			Have deliberately engaged in fire setting with the intention of causing serious damage.		
Have deliberately destroyed others' property (other than by fire setting).			Have broken into someone else's house, building or car		

Please answer if your child has used alcohol or any street drugs, if yes, which ones/ and when?:

_____

Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counsellor about an emotional or mental health problem? If yes, who and why?

_____

MEDICAL INFORMATION

Date of last physical exam: _____

Has your child experienced any of the following medical conditions during his/her lifetime?

◯Allergies ◯ Asthma ◯Headaches ◯Stomach aches
◯Chronic pain ◯Surgery ◯Serious accident ◯Head injury
◯Dizziness/fainting ◯Meningitis ◯Seizures ◯Vision problems
◯High fevers ◯Diabetes ◯Hearing problems ◯Ear infections
◯Miscarriage ◯Abortion ◯ Sleep disorder ◯Sexually transmitted disease
Other:_____

Family history of health problems or mental health problem: ----------
Please list any CURRENT health concerns:

_____

Current prescription medications: ◯ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

_____

Allergies and/or adverse reactions to medications: ◯ None

If yes, please list:

_____

PERSONAL AND DEVELOPMENTAL HISTORY

Please answer the following questions:

Was there any problems with mother's pregnancy? ◯Yes ◯No

How was the delivery? ◯ On time ◯ Early ◯ Late ◯ Forceps used ◯Caesarean

Any gross motor problems or difficulties? ◯ Yes ◯ No
(e.g. crawl, walk, two-wheeler, gym, sports)

Did you had any fine motor problems or difficulties? ◯ Yes ◯ No
(e.g. tracing, shoe laces, printing, writing)

Any language problems or difficulties? ◯ Yes ◯ No
(e.g. first language, first words, full sentences, stuttering)

Did people notice any odd behaviour with the child? ◯ Yes ◯ No
(e.g. rocking, flapping, no eye contact, odd play, head banging)

Did people notice any problems with child's temperament? ◯ Yes ◯ No
(eg. difficult, hyper, easy, quiet, happy, affectionate, calm,
self soothes, intense)

Any diagnosis with any learning ◯ Yes ◯ No
problems or disorders?

Being bullied. ◯ Yes ◯ No

Sexually abused between ages 5 – 10. ◯ Yes ◯ No

Sexually abused between ages 11 – 15. ◯ Yes ◯ No

Physically abused ◯ Yes ◯ No

Emotionally abused ◯ Yes ◯ No

SCHOOL INFORMATION

Current grade: _____

This year's school grades: ◯ Excellent ◯ Good ◯Fair ◯Poor
Past school grades: ◯ Excellent ◯ Good ◯Fair ◯Poor
This year's school behavior: ◯ Excellent ◯Good ◯Fair ◯Poor
Past school behavior: ◯Excellent ◯Good ◯Fair ◯Poor

Has your child had any of the following difficulties at school?

◯Suspension ◯ Incomplete homework ◯Learning problems ◯Referrals or detentions
◯Poor grades ◯ Teased or picked on ◯Speech problems ◯Attendance problems
◯Gang influence

Does your child have an after-school provider? ◯Yes ◯No
If so, who?

_____

Has your child ever repeated or skipped a grade? ◯Yes ◯No
If yes, which one(s)?

_____

Has your child ever received Special Education services? ◯Yes ◯No
If yes, please describe services received and reason for services:

_____

What does your child's teacher(s) say about him/her?

_____