Janet Muehe-Hayward
LCSW #23749
9067 Foothills Blv. suite #1
Roseville CA 95747

Child Mental Health Intake Form

Parents/Guardian's please complete all information on this form and bring to your child's first visit. It may seem long, but most of the questions require only a check, so it will go quickly. Thank you!

Name of person completing this form: _____

Relationships to child: _____ **Date:** _____

Child's Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Address:** _____

Telephone # _____

Do you give permission for ongoing regular updates to be provided to your primary care physician?

_____

What are your most important concerns for your child?

1._____
2._____
3._____

How are you hoping therapy will help your child?

_____
_____
_____

How many weeks/months are you willing/able to support your child's mental health?

____ 6-12 weeks
____ 3-6 months
____ 9-12 months
____ As long as child is benefiting from and needs therapy

Family Information:

Mother's Name: _____ Occupation: _____
Age: _____
Telephone numbers: _____
Address:_____
Relationship with child (good, stressed, not involved etc.)
_____

Father's Name: _____ Occupation: _____
Age: _____

Telephone numbers: _____

Address:_____

Relationship with child (good, stressed, not involved etc.)

_____

Stepmother's Name: _____ Occupation: _____
Age: _____

Telephone numbers: _____

Address:_____

Relationship with child (good, stressed, not involved etc.)

_____

Stepfather's Name: _____ Occupation: _____
Age: _____

Telephone numbers: _____

Address:_____

Relationship with child (good, stressed, not involved etc.)

_____

Brothers and Sisters: (please list from oldest to youngest)

Name	Age	Gender(M/F)	Relationship with child (good, stressed etc.)

Other persons residing in the home:

Name	Age	Gender(M/F)	Relationship with child (good, stressed etc.)

DEVELOPMENTAL HISTORY

Was the pregnancy planned? Y/N

If there were any complications during the pregnancy, please explain.

_____
_____
_____

Was the mother under emotional stress during the pregnancy? Y/N

If yes, what was stressful?

_____
_____
_____
_____

During pregnancy did the mother consume: Drugs Y/N Alcohol Y/N Tobacco Y/N Medications Y/N

If yes to any of the above, please give the type, amounts used, and frequency during the pregnancy:

_____
_____
_____
_____

Did the mother receive routine prenatal care? Y/N Birth weight of child: _____

Any difficulties with the birth? Please explain:

_____
_____
_____
_____

Were both mother and baby routinely discharged from the hospital at the same time? Y/N

If No, why?

_____
_____
_____

Please answer the following based upon you knowledge of normal development task

When did child walk? As expected Earlier than expected Later than expected Approx. age _____

Say his/her first word? As expected Earlier than expected Later than expected Approx. age _____ Talk in sentences? As expected Earlier than expected Later than expected Approx. age _____

Complete toilet training? As expected Earlier than expected Later than expected Approx. age _____

Were there any speech problems? If yes please explain below Y/N

_____
_____
_____

Has your child had speech therapy? If yes please explain below Y/N

_____
_____
_____
_____

EARLY CHILDHOOD PROBLEMS

Were there difficulties during infancy with:

Feeding Y/N Sleeping Y/N Colic Y/N Head banging Y/N Excessive Rocking? Y/N

If yes please provide details/examples here:

_____
_____
_____
_____

Please circle behaviors below which you noticed your child demonstrating **before age 5**:

Poor eye contact	Disliked being touched or held	Not cuddly
Would stare into space	Look through you	Lack of expression
Seemed in a shell	Seemed distant	Little interest in sharing
Need for sameness	Hard to know what he/she wants	Hard time talking to people
Unusual speech	Lines up toys	Spins toys
Echoes words	Flaps hands	Upset with change in routine
Bites or hurts self	Unusual food likes and dislikes	Lack of pretend play
Sensitive to light sound touch	Little reaction to pain	Attachment to things not people
Avoids adults other children	Nightmares	Night terrors
Bed wetting	Messing pants	Unusual fears
Aggression	Temper tantrums	Hyperactive
Inability to pay attention	Problems with other children	Being overly sensitive
Being a dare devil	Having no fear	Being bold
Being demanding	Difficulties with impulse control	

If yes to any of the above early childhood problems, please explain:

_____
_____
_____
_____
_____
_____
_____

Has your child ever been physically abused? Y/N

If yes, dates and how long the abuse lasted

_____
_____

Sexually abused? Y/N

If yes, dates and how long the abuse lasted

_____

_____

Psychologically abused? Y/N

If yes, dates and how long the abuse lasted

_____

_____

Please circle the symptoms below which you feel your child is currently experiencing:

Depressed mood	Racing thoughts	Excessive worry	Unable to enjoy activities
Impulsivity	Anxiety attacks	Sleep pattern disturbance	Increase risky behavior
Avoidance	Loss of interest	Hallucinations	Concentration/forgetfulness
Sleep Disturbance	Suspiciousness	Change in appetite	Excessive energy
Excessive guilt	Increased irritability	Fatigue	Crying spells
Argumentative	Fearful	School failure	Peer relational problems

Other:

_____

_____

_____

Suicide Risk Assessment:

Has your child ever expressed feelings or thoughts indicating they did not want to live or that they wanted to harm themselves in anyway (to you or anyone you are aware of)? Y/N

If YES, please answer the following:

When was the first time your child expressed feelings or thoughts of not wanting to live/suicide?

_____

When was the most recent time your child expressed feelings or thoughts of not wanting to live/suicide?

_____

How often does your child have these thoughts?

_____

Has anything happened recently that may have contributed to your child feeling this way?

_____

_____

On a scale of 1 to 10, (ten being strongest) how strong is your concern about your child's safety, ability/ willingness to harm themselves in any way? _____

Please explain one or two reasons for this number below:

_____

_____

What do you believe would help your child not to feel this way?

Has your child ever expressed a plan to you, or another person you know of, about how they would hurt/ harm/ kill themselves?

Is the method you would use readily available?

Have you planned a time for this?

Is there anything that would stop you from killing yourself?

Do you feel hopeless and/or worthless?

Have you ever tried to kill or harm yourself before?

Do you have access to guns or weapons? If yes, please explain.

Past Medical History:

Allergies_____ Current Weight _____ Height _____

List ALL current prescription medications and how often your child has taken them

Medication Name Total Daily Dosage Estimated Start Date

Current over-the-counter medications or supplements:

Current medical problems:

_____

_____

Past medical problems, non-psychiatric hospitalization, or surgeries:

_____

_____

Complete if needed/ or draw a diagonal line through:

Date of last menstrual period _____

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method _____

How many times have you been pregnant? _____

How many live births? _____

_____

_____

_____

Do you have any concerns about your child's physical health that you would like to discuss with me?

( ) Yes ( ) No

Date and place of last physical exam:

_____

Medical History: If your child has the condition listed please indicate with a X in the parentheses. If there is a family member with the condition listed please write the family members relationship to your child next to the condition.

( ) Thyroid Disease _____

( ) Anemia _____

( ) Liver Disease _____

( ) Chronic Fatigue _____

( ) Kidney Disease _____

( ) Diabetes _____

( ) Asthma/respiratory problems _____

( ) Stomach or intestinal problems _____

( ) Cancer (type) _____

( ) Fibromyalgia _____

( ) Heart Disease_____

( ) Epilepsy or seizures _____

( ) Chronic Pain _____

( ) High Cholesterol _____
( ) High blood pressure_____
( ) Head trauma _____
( ) Liver problems_____
Other:
_____

Is there any additional medical history you feel I should have? ( ) Yes ( ) No
If yes, please explain:
_____
_____
_____

Past Psychiatric History: Outpatient treatment ( ) Yes ( ) No
If yes, Please describe when, by whom, and nature of treatment. Reason Dates Treated By Whom
_____
_____
_____

Psychiatric Hospitalization ( ) Yes ( ) No
If yes, describe for what reason, when and where.
Reason Date Hospitalized Where
_____
_____
_____

Past Psychiatric Medications:
Dates Dosage Response/Side-Effects
_____
_____
_____
_____
_____

Current Psychiatric Medications:
Dates Dosage Response/Side-Effects
_____
_____
_____
_____
_____

Does your child exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

Family Psychiatric History:
Please circle any mental health conditions which one of your blood family members has/had

Bipolar disorder Schizophrenia Depression Post-traumatic stress
Anxiety Alcohol abuse Anger Substance abuse Suicide Attempt
Completed Suicide Violence

If yes please indicate your relationship to each person ?

_____

_____

_____

If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

_____

Substance Use: Has your child ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances?

_____

If yes, where and when

_____

Do you think your child may have a problem with alcohol or drug use? ( ) Yes ( ) No
If yes, which ones?

_____

How many caffeinated beverages does your drink a day? Coffee _____ Sodas _____ Tea _____
Tobacco History: Has your child used any tobacco products? ( ) Yes ( ) No

Trauma History:
Does your child have a history of being abused emotionally, sexually, physically or by neglect?
( ) Yes ( ) No.
Please describe when, where and by whom:

_____

_____

_____

_____

School/Academics

Your child's current grade? ____ Has he/she ever repeated a grade? ( )Yes ( ) No

If so, which? _____

School name: _____Public or Private (circle one)

Street Address:

_____

_____

School District/County? _____ Phone: ___(____)_____

What preschool experience did your child have? _____

Where any problems detected in your child's kindergarten screening? Yes No

If so, please explain:

_____

_____

Is your child in a regular classroom? ( ) Yes ( ) No Does your child have an IEP ? ( )Yes ( ) No

Has your child ever received tutoring? ( )Yes ( )No

If so, please explain:

_____

What are your child's typical grades?

_____

What are your child's strongest and weakest points academically?

_____

_____

_____

Are you satisfied with your child's educational program? ( )Yes ( )No

Please explain:

_____

_____

Legal History:

Are both child's parents (circle below)

Married living together Separated Divorced

If both parents are not married and/or not living together please explain the circumstances:

_____

_____

Are both parents in agreement regarding child's need for therapy? ( ) Yes ( ) No

Are both parents willing to sign the Consent To Treat a Minor ( ) Yes ( ) No

If no is there a court document giving authority to one parent to independently seek mental health treatment for child? ( )Yes ( )No

If yes please bring this document to the initial session with you.

Has your child ever been arrested?

_____

_____

Does your child have any pending legal problems?

_____

_____

Does anyone living with or significantly involved with your child have any legal issues which may in some way impact your child? If so please explain:

_____

_____

_____

_____

Spiritual Life:

Do you and/or your child belong to a religious or spiritual group? ( ) Yes ( ) No

If yes, what is the level of involvement? (wkly, on occasion etc.) _____

Do you find this involvement helpful or does the involvement make things more difficult or stressful for anyone in your family including your child?

_____

_____

Support System:

Please tell me about your support system. This can include people you live with, family members, friends, mentors, neighbors, professionals … anyone you can reach out too during difficult times.

_____

_____

_____

_____

What else should I know so I can help you?

_____

_____

_____

_____

_____

Name of person completing this form:

_____

Signature_____

Date_____

Emergency Contact _____

Relationship _____

Telephone # _____