Dr Marti Fausold-Mowers
Child / Adolescent Intake Questionnaire – PARENT FORM

NOTE: This form to be completed by the Parent / Guardian for any patients under 18 Years of age.

Child / Adolescent Name Gender

DATE of BIRTH Address

Natural Child If adopted, at what age Foster since

Parent's Names and contact (include step parents, foster parents, etc):

NAME *	RELATION	Cell Phone	E Mail

* Please designate with * for Primary Contact person

Comments about custody and visitation (if applicable):

Primary Reason you are concerned about your child:

Medical Insurance

Name of Child's Pediatrician

Has your child seen a therapist, psychiatrist or other mental health professional before?

If yes, please complete:

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SYMPTOM CHECKLIST

Please check ant symptoms or experiences that you have had in the last month:

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulty getting out of bed
- ☐ Not felling rested in the morning

Average hours of sleep

- ☐ Persistent loss of interest in previously enjoyed items
- ☐ Withdrawing from other people
- ☐ Spending increased time alone
- ☐ Depressed mood
- ☐ Feeling numb
- ☐ Rapid Mood changes
- ☐ Irritability
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Frequent feelings of guilt
- ☐ Avoiding people, places, activities
- ☐ Difficulty leaving your home
- ☐ Outbursts of anger
- ☐ Fear of certain objects or situations (i.e. flying, heights, bugs)
- ☐ Repetitive behaviors or mental acts (i.e. counting, checking doors, washing hands)

- ☐ Worthlessness
- ☐ Hopelessness
- ☐ Sadness
- ☐ Helplessness
- ☐ Fear
- ☐ Feeling or acting like a different person

- ☐ Changes in eating / appetite
- ☐ Eating more
- ☐ Eating less
- ☐ Voluntary vomiting
- ☐ Use of laxatives
- ☐ Excessive exercise to avoid weight gain
- ☐ Binge eating
- ☐ Are you trying to lose weight?
- ☐ Weight gain:
- ☐ Weight loss:

- ☐ Difficulty in catching your breath
- ☐ Increase muscle tension
- ☐ Unusual sweating
- ☐ Easily started, feeling “jumpy”
- ☐ Increased energy
- ☐ Decreased energy
- ☐ Tremor
- ☐ Dizziness
- ☐ Frequent worry
- ☐ Physical sensations others don’t have
- ☐ Racing thoughts
- ☐ Intrusive memories

- ☐ Difficulty concentrating or thinking
- ☐ Large gaps in memory
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Thoughts about harming or killing yourself
- ☐ Thoughts about harming or killing someone else

- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Feeling puzzled as to what is real and unreal
- ☐ Persistent, repetitive, intrusive thoughts, impulses, or images

☐ Unusual visual experiences such as flashes of light, shadows
☐ Hear voices when no is present
☐ Feeling that your thoughts are controlled or placed in your mind
☐ Feeling that television or the radio is communicating with you
☐ Feeling as if you were outside yourself, detached, observing what you are doing

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☐ Difficulty problem solving
☐ Dependency on others
☐ Inappropriate expression of anger
☐ Difficulty/Inability to say “no” to others
☐ Sense of lack of control
☐ Abusive relationship
☐ Difficulty meeting expectations
☐ Manipulation of others to fulfil your own desires
☐ Self-mutilation / cutting
☐ Ineffective communication
☐ Decreased ability to handle stress
☐ Difficulty expressing emotions

SCHOOL HISTORY

Has child ever repeated a grade

Is child in Special Services

Describe

Please describe academic or other problems your child has in school:

FAMILY HISTORY

All Family Relations are with respect to the Child - Patient

Father

If Deceased, His Age at time of his Death

Child’s Age at time of Death

Occupation

Overall Health

Frequency of Contact with him

Was / Is Child close to him?

Mother

If Deceased, His Age at time of her Death

Child’s Age at time of Death

Occupation

Overall Health

Frequency of Contact with her

Was / Is Child close to her?

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List of Child's Siblings

Name	Gender	Age	Do they live with patient?

Mental Health Symptoms of Relatives

Check All that Apply	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grandparents
Nervous Problems	○	○	○	○	○	○
Depression	○	○	○	○	○	○
Hyperactivity	○	○	○	○	○	○
Counseling	○	○	○	○	○	○
Psychiatric Medication	○	○	○	○	○	○
Psychiatric Hospitalization	○	○	○	○	○	○
Suicide Attempt	○	○	○	○	○	○
Death by Suicide	○	○	○	○	○	○
Drinking/Drug Problem	○	○	○	○	○	○