Germantown Psychological Associates, P.C.

7516 Enterprise Avenue, Suite 1
Germantown, TN 38138
Tel: 901-755-5802
Fax: 901-757-2249

Received From Parent/Patient:

A

CHILD ADOLESCENT YOUNG ADULT
Intake/History Questionnaire

Patient's Name:_______________________ **Birth Date:**___/___/____ **Age:**___ **DATE:** __/__/__ **Sex: M F**

Address - Street: ____________________________ City: _________________ State: ____ Zip: __________

Parent/Guardian Information:

Home Phone: (_____)______-________ Mom's Cell : (_____)______-_________ Dad's Cell : (_____)- _____- _______

Father's Name:___________________Employment:___________________ E-Mail: _____________________

Mother's Name: ________________ Employment:__________________E-Mail: ___________________

If the child does not live with either biological parent, who does he/she live with?_______________________

Is this child adopted? ☐ **YES** ☐ **NO**

REASON FOR COMING IN TODAY: ☐ **Evaluate / Diagnosis** ☐ **Therapy** ☐ **Testing** ☐ **Legal**
☐ **Other Concerns:**____

WHAT PROBLEMS/DIFFICULTIES HAS YOUR CHILD BEEN HAVING LATELY: _____________
____
____

DESCRIBE CURRENT STRESSORS AT HOME, IF ANY: ____________________________________
____

BEHAVIOR CHECKLIST

BEHAVIOR	Check if Current Problem	If checked, please provide additional information
Fidgets		
Daydreams		
Blurts out in class		
Difficulty completing task		
Excessive talking		
Difficulty waiting turn		
Difficulty staying seated		
Interrupts others		
Impulsive		
Often loses things		
Difficulty staying organized		
Bored easily		
Difficulty following instructions		
Always on the "go"		

© Luscomb & Sanders - 2000, 2001,2006, 2011, 2014 Germantown Psychological Associates, P.C.

BEHAVIOR	Check if Current Problem	If checked, please provide additional information
Argumentative with parents		
Argumentative with other adults		
Temper tantrums		
Rageful behavior		
Stealing		
Running away		
Fighting/kicking		
Dangerous activities		
Destructive		
Acts younger than age		
Accident prone		
Easily frustrated		
Moodiness		
Suicidal Thoughts/attempts/threats		
Depressed or sad		
Eating disorder concerns		
Suspensions/expulsions		
Fears		
Unusual routines/habits		
Difficulty making/keeping friends		
Lies		
Defiant to authority		
Anxious or worries excessively		
Perfectionistic behaviors		
Easily distracted		
Difficulty with being on time		
Forgetful		
Smokes cigarettes		
Drug or alcohol concerns		
Cuts on self		

B

HISTORY OF PREVIOUS THERAPY AND/OR TESTING for ADHD, LD, Anxiety, Depression

Professional	Dates of Treatment	Diagnosis

*Continue on back of form if more space is needed

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.

FAMILY INFORMATION

FAMILY COMPOSITION

SIBLINGS (include step/half) and others living in the home (grandparents, aunts, uncles)	Male(M) Female (F)	Age	Biological, half-sibling or step-sibling	Does individual live with patient?	Describe the quality of their relationship

***Continue on back of form if more space is needed.**

Status of parents: ☐ married ☐ never married ☐ separated ☐ divorced (age of child at time of divorce: ____)

Mother remarried: ☐ Yes ☐ No If yes, spouse's name:____

Father remarried: ☐ Yes ☐ No If yes, spouse's name:____

If divorced, who has primary custody? ☐ Joint ☐ Mother ☐ Father ☐ Other ____________________

Visitation schedule (if divorced or separated):____

Are there any legal issues pending? ☐ No ☐ Yes – Explain: ______________________________________

Recent family illness or deaths:_____________________________ Favorite relative:______________________

Recent changes in living situation: ____

FAMILY OF ORIGIN

Biological or Adoptive Mother (circle one)

Name:____ Living Deceased

If living, current place of residence:____Age:_____

Highest grade completed in school:_______Learning problems:_____________________________

# of Marriages:______

History of alcohol/drug use:____

History of psychiatric treatment:____

Biological or Adoptive Father (circle one)

Name:____ Living Deceased

If living, current place of residence:____Age:_____

Highest grade completed in school:_______Learning problems:____________________________________

# of Marriages:______

History of alcohol/drug use:____

History of psychiatric treatment:____

Other Guardians: ____

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.

SOCIAL DEVELOPMENT

Does your child have difficulty making or keeping friends? ❒ Yes ❒ No
If yes, please describe: ____
____
Does your child have a best friend? ❒ Yes ❒ No
Does your child show interest in playing with other children on a regular basis? ❒ Yes ❒ No
Your child's friends tend to be: ❒ Younger ❒ Same Age ❒ Older

EXTRACURRICULAR ACTIVITIES

List the activities your child is currently involved in after school: ______________________
____
Has there been a recent increase or decrease in activity involvement? ❒ Yes ❒ No If yes, please
Explain: ____
What concerns, if any, have coaches or group leaders shared with you about your child: ________
____

CURRENT DISCIPLINE USED WITH YOUR CHILD

DISCIPLINE	YES	NO	RESPONSE
Time outs			
Loss of privileges			
Physical punishment			
Talking			
Rewards			
Yelling			
Send to room			

Who is the primary disciplinarian in your home? ______________________________________
How consistent is your discipline alone?_____________with spouse?______________

C

SCHOOL HISTORY (Preschool-12th grade)

School	Grade(s) attended	Average Grades	Difficulties Noted

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.

SCHOOL HISTORY [CONTINUED]

Current School: ____________________ Grade: _____ Current areas of difficulty:_________________
Amount of time spent on homework: _______ Can child complete homework by self? ❒ Yes ❒ No
Much unfinished work: ❒ Yes ❒ No Errors in work are: ☐ Impulsive ☐ Careless ☐ Conceptual
Grades failed/repeated (please circle any that apply): K 1 2 3 4 5 6 7 8 9 10 11 12
Has your child been identified by the school system under 504 or any special needs program? ❒ Yes ❒ No
Does your child have a current Individual Education Plan [IEP]? ❒ Yes ❒ No
Does your child receive any academic modifications?: ❒ Yes ❒ No – Describe ______________________
____

D

MEDICAL INFORMATION:

Patient's Physician:__________________________ **Office Phone: (____)_____-**___________________

Date of last Physical: [ ] **Vision Exam:** [ ] **Hearing Exam:** [ ]

Glasses/Contacts? ☐ **Yes** ☐ **No** **Hearing Difficulties?** ☐ **Yes** ☐ **No** **Speech Difficulties?** ☐ **Yes** ☐ **No**

CURRENT MEDICATIONS for AD/HD, Depression, Anxiety, OCD, Allergies or Medical Condition(s)

Please include supplements / vitamins

Medication and Dosage	Prescribed for	Physician	Response to Medication

***Continue on back of form if more space is needed**

PAST HISTORY OF MEDICATIONS for AD/HD, Depression, Anxiety, OCD, or Medical Condition(s)

Medication	Prescribed for	Physician	Response to Medication

Is your child allergic to any medications, foods, or environmental issues? If so, please list:

____

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.

DEVELOPMENTAL HISTORY

Complications during mother's pregnancy: ❐ Yes ❐ No (Please provide info if YES)________________________
Premature? ❐ Yes ❐ No – weeks: ___________ Birth weight:_________

During pregnancy, did the child's mother use: **Cigarettes?** ❐ Yes ❐ No **Alcohol?** ❐ Yes ❐ No

Prescription Medications? ❐ Yes ❐ No _________________ **Drugs?** ❐ Yes ❐ No __________________

Any complications or hospitalizations as an infant? ❐ Yes ❐ No (Please provide info if YES)_________________

Current weight:______ Current height:_____Current/Past Physical Disabilities? ❐ Yes ❐ No_____________

____

Has your child been involved in, current or past: ☐ Speech Therapy ☐ Occupational Therapy
☐ Physical Therapy ☐ Other __________________

If yes, when? __________________Why?_______________ Who provided the therapy? __________________

DEVELOPMENTAL MILESTONES

AREA	Within Normal Limits	Delayed	Age if you remember	Comments
Sitting Alone				
Walking				
Talking				
Potty Training				
Riding bike/climbing stairs				
Writing/penmanship				

CHILD MEDICAL HISTORY

*** PLEASE BE AS COMPLETE AS POSSIBLE IN YOUR RESPONSES**

AREA	Check if *Past* Problem	Check if *Current* Problem	If Yes, please provide additional information
Ear infections	❐ Yes	❐ Yes	
Tubes in ears	❐ Yes	❐ Yes	
Concussion	❐ Yes	❐ Yes	
Head trauma	❐ Yes	❐ Yes	
Seizures	❐ Yes	❐ Yes	
Hearing difficulties	❐ Yes	❐ Yes	
Vision problems	❐ Yes	❐ Yes	
Eating problems	❐ Yes	❐ Yes	
Asthma, history or current	❐ Yes	❐ Yes	
Diabetes	❐ Yes	❐ Yes	
Bedwetting	❐ Yes	❐ Yes	
Daytime wetting	❐ Yes	❐ Yes	
Constipation	❐ Yes	❐ Yes	

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.

CHILD MEDICAL HISTORY – [continued]

AREA	Check if *Past* Problem	Check if *Current* Problem	If Yes, please provide additional information
Soiling pants	❒ Yes	❒ Yes	
Speech difficulties	❒ Yes	❒ Yes	
Chronic illness/complaints	❒ Yes	❒ Yes	
Stomach problems	❒ Yes	❒ Yes	
Allergies (food, meds, environ.)	❒ Yes	❒ Yes	
Surgery	❒ Yes	❒ Yes	
Broken bones	❒ Yes	❒ Yes	
Sleep difficulties	❒ Yes	❒ Yes	
Nightmares	❒ Yes	❒ Yes	
Significant accidents	❒ Yes	❒ Yes	
Hospitalizations / ER Visits	❒ Yes	❒ Yes	
History of sexual abuse	❒ Yes	❒ Yes	
History of physical abuse	❒ Yes	❒ Yes	
History of verbal abuse	❒ Yes	❒ Yes	
History of heart condition	❒ Yes	❒ Yes	
(Girls) age of first period	❒ Yes	❒ Yes	
Growth concerns	❒ Yes	❒ Yes	
Thyroid problems	❒ Yes	❒ Yes	
Cancer History	❒ Yes	❒ Yes	
Other:	❒ Yes	❒ Yes	

Does your child have a specific medical diagnosis other than those listed above? ❒ Yes ❒ No

If yes, what is this diagnosis? ____________________ When was this diagnosis given? ________________

Who is your child’s treating physician for this diagnosis? ____

What other information do you need to share about this diagnosis? _________________________________

Does your child have any other chronic disorders? ❒ Yes ❒ No

If yes, please describe: ____

Does your child have any other genetic disorders? ❒ Yes ❒ No

If yes, please describe: ____

Risk Assessment: Has there ever been, or is there currently, any evidence of the following:
☐ Sexual/Physical Abuse ☐ Violence ☐ Suicidal Behavior ☐ Homicidal Behavior ☐ Substance Abuse
None of the above apply ➔☐
Do you have Firearms in the Home: ❒ Yes ❒ No If yes, do you have a safety plan: ❒ Yes ❒ No

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.

FAMILY MEDICAL / PSYCHIATRIC HISTORY

E

Check all that Apply

AREA	Mother	Father	Siblings	Mother's Family	Father's Family
Alcohol Abuse					
Drug Abuse					
Depression					
Bipolar/Mood Disorder					
Obsessive-Compulsive					
Anxiety					
ADHD					
Learning difficulties					
School difficulties					
Dyslexia					
Schizophrenia					
Neurological Disorders					
Seizures					
Tics/Tourettes					
Heart Health Issues					
High Blood Pressure					
High Cholesterol					
Diabetes					
Cancer					
Thyroid					
Allergies					

Are any of your child's family members currently in therapy? ❒ Yes ❒ No
If yes, who and for what diagnosis? ________________________________
Who is the professional treating this family member? ____________________________________

PARENT'S GOALS FOR THERAPY

1. ____
2. ____
3. ____

YOUR CHILD'S STRENGTHS:

1. ______________________________
2. ______________________________
3. ______________________________

YOUR CHILD'S WEAKNESSES:

1. ______________________________
2. ______________________________
3. ______________________________

NOTE: If there is information not addressed in this history/intake form, please provide on the back. Thank you.

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.

If the patient is between the ages of 18 and 24, please have him/her complete this section

ALCOHOL AND/OR DRUG HISTORY

Your use of alcohol and/or drugs is an important part of your history. Please list age started, types of substances used, and current usage. Substances include, but not limited to: alcohol, marijuana, hash, prescription medications abused, inhalants, cocaine, crack, amphetamines, crank, steroids, heroin, morphine, barbiturates, LSD, mescaline, mushrooms, PCP, ecstasy, ketamines and any others.

Substance	Age Started	How long? (yrs,mos)	Current ?
			Yes ❐ No ❐
			Yes ❐ No ❐
			Yes ❐ No ❐
			Yes ❐ No ❐
			Yes ❐ No ❐
			Yes ❐ No ❐
			Yes ❐ No ❐
			Yes ❐ No ❐
			Yes ❐ No ❐

History of treatment for substance abuse: In-patient, out-patient, AA and/or NA: ________________

____

____

Has anyone ever told you they thought you had a problem with drugs or alcohol? Yes ❐ No ❐

Have you ever thought you had an alcohol or drug problem? Yes ❐ No ❐

Have you ever tried to cut back or quit unsuccessfully? Yes ❐ No ❐

Have you ever experienced blackouts (memory loss) after using alcohol/drugs? Yes ❐ No ❐

Have you ever used alcohol or drugs first thing in the morning? Yes ❐ No ❐

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate):_________________________________

Nicotine use per day, past and present:____

Cigarettes ❐ Chewing Tobacco ❐ Other ❐ _______________________________________

FAMILY HISTORY : If this does not apply, please circle: N/A

Patient's Spouse / Significant Other Name: _________________________________ Age: _________

Current issues in this relationship (separation, pending divorce, abuse, etc.): ________________________

____

PATIENT'S CHILDREN: If this does not apply, please circle: N/A

Name	**Age**	**Sex**	**Current residence**	**Biological/Adopted/Step-child**

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.

EMPLOYMENT HISTORY

List the jobs you've had since age 18. Indicate which jobs you liked and which ones you did not. Also, describe any work-related problems that you have experienced:

Age	Place of Employment	Responsibilities	How long?	Did you enjoy job?
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒
				Yes ❒ No ❒

What would your employers or supervisors say about you?______________________________________

____

EDUCATIONAL HISTORY

Completed High School: Yes ❒ No ❒ If not, highest grade completed:______ GED: Yes ❒ No ❒

Average Grades in school:__________Best subject:____________Worst subject:____________________

Did you repeat a grade? Yes ❒ No ❒ If yes, which grade and why?______________________________

Were you ever in resource classes for any subject? Yes ❒ No ❒ If yes, which subject(s)?_____________

____

Did you attend or are you currently in college? Yes ❒ No ❒ If yes, where?______________________

Did you complete college? Yes ❒ No ❒ What is your degree in?______________________________

Are you in graduate school? Yes ❒ No ❒ If yes, where ? _________________________________
If yes, what graduate degree are you pursuing?____

Did you have any specific academic or behavioral problems that you recall in elementary, middle, or high school? Yes ❒ No ❒ If yes, please give as much detail as you can recall: _____________________

____

If you are currently in school, please share any current problems/difficulties that you are experiencing in academic environment: ____

If you are currently in school, are you receiving any academic modifications? Yes ❒ No ❒

If Yes, please list accommodations:____

SEXUAL HISTORY:

Do you have a history of sexual abuse or sexual assault? Yes ❒ No ❒

If yes, please give details if you are comfortable:__________________________________

____

PLEASE RETURN TO YOUR GPA CLINICIAN

© Luscomb & Sanders- 2000, 2001,2006, 2011, 2012, 2014 - Germantown Psychological Associates, P.C.