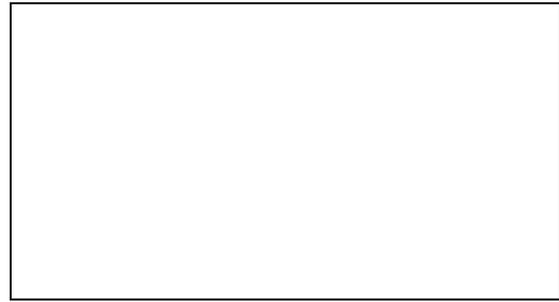




Department of Psychiatry Behavioral Medicine

PSYCHIATRIC INTAKE ASSESSMENT
CHILD/ADOLESCENT



Time in: _____ Accompanied by: _____

Emergency name and number: _____

Relationship to the patient: _____

Patient Alternate phone number: _____

Allergies: None known: _____ Explain: _____

CURRENT MEDICATIONS:

Name:	Dosage/Frequency	When started

CHIEF COMPLAINT/DURATION: (per triage sheet) _____

MEDICAL HISTORY:

B/P _____ P _____ Ht: _____ Wt: _____

Primary care physician: _____

Recent labs: Yes: _____ No _____ Details: _____

EEG: Yes _____ No _____ Why? _____ When? _____ Where? _____

CT/MRI: Yes _____ No _____ Why? _____ When? _____ Where? _____

	Y	N	COMMENTS
Constitutional (eg: weight loss, fever)			
Cardiovascular/Hypertension			
GI/Liver			
Neurological (eg: seizure, CVA)			
Musculoskeletal			
Hematologic/Lymphatic			
Cancer			
HEENT			

	Y	N	Comments
GU			
Skin			
Endocrine (eg: diabetes, thyroid)			
Allergic/Immunologic			
Head/trauma			
Hospitalizations			
Surgeries			
Significant Dx's			

Biological Family Medical History:

	Y	N	Comments
Cardiovascular/Hypertension			
GI/Liver			
Neurological (eg: seizures, CVA, Parkinsons, Huntingtons)			
Cancer			
Respiratory (eg: COPD, asthma)			
GU			
Endocrine			
Other			
Alcohol/Substance abuse			
Psychiatric			

SOCIAL HISTORY:

Household members: _____

Parents divorced?

Yes: _____ When? _____ No: _____ Never married: _____

Born where? _____

Current school: _____

Current grade: _____

In Special Education? Yes/No, Describe: _____

Legal issues (probation, name of juvenile court officer): _____

Previous out of home placements:

Placement	Dates
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History of physical, emotional, sexual abuse: _____

Substance abuse history, treatment, current use: _____

Psychiatric history: _____

Current stressors: _____

<u>Vegetative Symptoms:</u>	<u>YES</u>	<u>NO</u>	<u>COMMENT</u>
Sleep	_____	_____	_____
Appetite	_____	_____	_____
Energy	_____	_____	_____
Interest/Motivation	_____	_____	_____
Concentration	_____	_____	_____
Memory	_____	_____	_____
Hopelessness	_____	_____	_____

Manic Symptoms: _____

Anxiety Symptoms: _____

OCD Symptoms: _____

Psychotic Symptoms: _____

Suicidal or Self-injuries Behaviors: (ideation, plan, intent, means, attempt, etc.)
Current: _____

Past: _____

Homicidal or Assaultive Behaviors: _____

Eating Disorder: _____

Cognitive Deficits: (orientation, MR, intellectual decline, wandering, language)

ADD Symptoms: _____

DEVELOPMENTAL HISTORY

Pregnancy complications:

Maternal substance abuse during pregnancy: (alcohol or other)

Perinatal complications:

Illnesses during infancy (first year):

Age when first walked: _____

Age when first talked in phrases/short sentences: _____

Age when toilet training was completed: _____

Any enuresis/encopresis currently: No _____ Yes _____

Details: _____

Social development:

Spontaneous interest in friends?

Other: _____

RN Intake Signature: _____



MEDICAL ASSOCIATES
C L I N I C

Department of Psychiatry/Behavioral Medicine

Mental Status Exam

Appearance: WNWD Other: _____
 Well kept Mod kempt Unkempt

Motor activity: Appropriate restless/agitated retarded
 Abnormal movements _____

Speech: Fluent, goal oriented Other: _____
Associations: Intact Loose Tangential

Affect: Bright Labile Irritable Sad
 Anxious Constricted Flat
 Other: _____

Intelligence: Average Above Ave. Low Normal Retarded

Orientation: Name Time Place **COMMENTS:** _____
(check, if normal)

Memory: Immediate Intact Other _____
Recent: Intact Other _____
Remote: Intact Other _____

Delusions/Hallucinations: No Yes

Details _____

Mood: _____

Insight: Normal Other: _____

Judgement: Normal Other: _____

Suicide Assessment: None Other: _____

MMSE _____/30 Details: _____

Comments: _____



MEDICAL ASSOCIATES
C L I N I C

Department of Psychiatry/Behavioral Medicine

Physician's Impression:

Nursing Evaluation _____ reviewed
Date

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V (Global Assessment of Functioning Scale – Present):

1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
Lethality Persists	Lethality Same	Function Poor	Function Impaired	Symptoms Severe	Symptoms Moderate	Symptoms Mild	Symptoms Transient	Symptoms Minimum	Symptoms None

PLAN:

Medications: ↑ Continue same
 ↑ Change: _____

Risk & benefits explained including: _____

Other instructions: _____

Return to Clinic: _____

The patient has been informed to call in the interim should any problems arise.

The patient voices an understanding of the plan.

CC: _____

Signature Doctor _____ Date _____

Time Out ____:_____