MIND FLEX LLC
115 Pheasant Run Suite 212
Newtown, Pa 18940

CHILD/ADOLESCENT INTAKE

ALL INFORMATION IS CONFIDENTIAL

GENERAL INFORMATION

Date: _____

Referred by: _____

Reason for Referral: _____

PATIENT INFORMATION

Patient Name _____ Date of Birth ___/___/___ Age _____

Sex _____ Male _____ Female Social Security # _____

Ethnicity ____ Caucasian ____ African American ____ Hispanic ____ Other _____

Address _____

_____, _____ _____
(city) *(state)* *(zip code)*

Home phone (_____)_____

MEDICAL HEALTH INSURANCE INFORMATION

Primary Insurance Carrier _____

Address _____

_____, _____ _____
(city) *(state)* *(zip code)*

Insurance Phone (_____)_____ Mental Health Phone (_____)_____

Subscriber Name _____ Date of Birth ____/____/____

Subscriber's Employer _____

Policy # _____ Group # _____

PARENT/GUARDIAN INFORMATION

(please use additional sheet for other relations—i.e. step-parents or other individuals who are very involved in child/adolescent's life)

Parent Name#1 _____ Date of Birth ___/___/___ Age _____

Address _____ Soc Sec # _____
(if different than child/adolescent)

_____, _____ _____
(city) *(state)* *(zip code)*

Home phone (_____)_____Work phone (_____)_____ext. _____

Email _____Fax (_____)_____ Other_____

Employer Name _____ Occupation _____

Employer Address _____
(street) *(city, state, zip code)*

Hours per week _____

Parent Name#2 _____ Date of Birth ___/___/___ Age _____

Address _____ Soc Sec # _____
(if different than child/adolescent)

_____, _____ _____
(city) *(state)* *(zip code)*

Home phone (_____)_____Work phone (_____)_____ext. _____

Email _____Fax (_____)_____ Other_____

Employer Name _____ Occupation _____

Employer Address _____
(street) *(city, state, zip code)*

Hours per week _____

CHILD/ADOLESCENT'S LIVING SITUATION

Parent's Relationship Status_____

Length of Marriage/Relationship _____

Please describe relationship.

Very satisfactory _____

Satisfactory _____

Tolerable _____

Intolerable _____

Minor but persistent problems and conflicts _____

Major and persistent problems and conflicts _____

Please describe any current or past problems or conflicts

_____

_____

_____

Please list all of the child/adolescent's siblings, including date of birth, age, sex, and relationship to child/adolescent (sister, half-brother, step-brother, adopted, etc.). Please list in order from oldest to youngest and include in the list the individual who is being referred to us.

Names of Siblings	**Sex**	**Date of Birth**	**Age**	**Relationship**

Please describe relationship between child/adolescent and siblings.

_____

_____

_____

Please list all individuals who currently live or reside with the child/adolescent (even ½ time, i.e. away at college), including date of birth, age, sex, and relationship to child/adolescent.

Names	**Sex**	**Date of Birth**	**Age**	**Relationship**

Please describe any current or past household problems including drug/alcohol abuse, family or personality conflicts, financial difficulties, legal problems, physical/emotional abuse or neglect, illness or death, work conflicts, religious conflict, house or environment issues, special needs of any household members. Also, please describe any major environmental changes such as moving, remodeling, job or school changes.

Who are the most important individuals in the child/adolescent's life?

Is English the only language spoken in the home? Yes _____ No _____
If "No," which languages are spoken. Please indicate the main language spoken.

Was the child/adolescent born in the United States? _____If not, where was he/she born and when was he/she brought to the U.S.? _____

Child/Adolescent Name:_____

Parent/Guardian Signature_____

Date: _____

GENERAL HEALTH INFORMATION

Family Doctor _____

Address _____

_____, _____ _____
(city) *(state)* *(zip code)*

Office phone (_____)_____ Office fax (_____)_____

May we contact this individual/office regarding treatment? _____ Yes _____ No

Pediatrician _____

Address _____

_____, _____ _____
(city) *(state)* *(zip code)*

Office phone (_____)_____ Office fax (_____)_____

May we contact this individual/office regarding treatment? _____ Yes _____ No

Other Health Provider (please specify specialty) _____

Name _____

Address _____

_____, _____ _____
(city) *(state)* *(zip code)*

Office phone (_____)_____ Office fax (_____)_____

May we contact this individual/office regarding treatment? _____ Yes _____ No

FAMILY MEDICAL HISTORY (DO NOT INCLUDE CHILD/ADOLESCENT)

	Yes	No	Who/Explain
Allergies	____	____	_____
Asthma	____	____	_____
Diabetes	____	____	_____
Hypoglycemia	____	____	_____
Arthritis (rheumatoid)	____	____	_____
Colitis/ileitis	____	____	_____
Thyroid Disorder	____	____	_____
Migraines	____	____	_____
Sleep Disorders	____	____	_____
Schizophrenia	____	____	_____
Anger/Rage	____	____	_____
Reading Difficulties	____	____	_____
Spelling Difficulties	____	____	_____
Arithmetic Difficulties	____	____	_____
Snoring	____	____	_____
Vision Problems	____	____	_____
Depression	____	____	_____
Manic depression	____	____	_____
Phobias/Panic Attacks	____	____	_____
Motor or vocal tics	____	____	_____
Seizures/Epilepsy	____	____	_____
Eating Disorders/Obesity	____	____	_____
Addictions/alcoholism	____	____	_____

Obsessive/Compulsive	____	____	_____
Speech Problems	____	____	_____
Hyperactivity	____	____	_____
Learning Problems	____	____	_____
L-handed/ambidextrous	____	____	_____
Anti-social behavior	____	____	_____
High blood pressure	____	____	_____
Heart Disease	____	____	_____
GI/GU Disorders	____	____	_____
Ulcer (active)	____	____	_____
Cancer	____	____	_____
Osteoporosis	____	____	_____
Multiple sclerosis	____	____	_____
Liver disease	____	____	_____
Kidney disease	____	____	_____
Gout	____	____	_____
Seasonal mood/behavior Changes	____	____	_____
Sleep walking	____	____	_____
Other_____	____	____	_____

Has the child/adolescent ever undergone an

EEG (Electroencephalogram) _____ Yes _____ No

Cat scans _____ Yes _____ No

MRI _____ Yes _____ No

Allergy Testing _____ Yes _____ No

Nutritional Testing _____ Yes _____ No

Hair Analysis _____ Yes _____ No

Glucose Intolerance Test _____ Yes _____ No

EDUCATION INFORMATION

Current School _____

Address _____

_____, _____ _____
(city) *(state)* *(zip code)*

Office phone (_____)_____ Office fax (_____)_____

Grade: _____ Type of class _____
(standard, inclusion, gifted, special ed, etc.)

Principal Name _____

Teacher(s) Name(s)_____

Overall IQ _____ Verbal IQ _____ Performance IQ _____

Best Subject _____ Favorite Subject _____

Worst Subject _____ Least Favorite _____

Describe child/adolescent's school performance including any academic or behavior problems

_____

_____

_____

Previous Education History

Name/Type School	**City, State**	**Grade/Level/Type class**
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

CHILD/ADOLESCENT'S MEDICAL HISTORY

(For any of these areas, please feel free to include additional sheets of explanation and/or copies of additional information, e.g. doctor reports, written records, baby diaries, etc. If you cannot remember details of any information, please note with "CR"-"Can't remember"

If adopted, check here _____. If so, at what age _____. From where _____

Pregnancy

_____ Normal Term _____ Weeks Premature _____Weeks Overdue

Special Circumstances during pregnancy such as illnesses, medications taken (names/dosages), complications. Please explain in detail and indicate how many weeks into pregnancy.

_____

_____

_____

_____

Birth Setting (home, hospital, etc.) Please explain details.

_____

Name and Address of Hospital/Clinic/Doctor

_____

_____

Birth Weight _____ lbs. _____oz. Length _____ inches

APGAR score _____ Length of Labor _____

Were there any difficulties, complications, unusual features about the birth? Please explain in detail.

_____

_____

INFANCY/EARLY CHILDHOOD

Has the child/adolescent had any of the following. Please check Yes/No, summarize details, and indicate age of occurrence.

	Yes	No	Details	Age(s)
High Fevers	____	____	_____	_____
Convulsions/Fits	____	____	_____	_____
Eczema	____	____	_____	_____
Encephalitis	____	____	_____	_____
Rheumatic Fever	____	____	_____	_____
Epilepsy/Seizures	____	____	_____	_____
Chicken Pox	____	____	_____	_____
Jaundice	____	____	_____	_____
Mumps	____	____	_____	_____
Measles	____	____	_____	_____
Asthma	____	____	_____	_____
Silent periods	____	____	_____	_____
Bed wetting	____	____	_____	_____
Soiling	____	____	_____	_____
Nightmares	____	____	_____	_____
Headaches	____	____	_____	_____
Silent periods	____	____	_____	_____
Fainting/Black outs	____	____	_____	_____

Nervousness/Anxiety	____	_____	_____	_____
Timidity/Shyness	____	_____	_____	_____
Extreme Jealousy	____	_____	_____	_____
Sleep Problems	____	_____	_____	_____
Difficulty falling Asleep	____	_____	_____	_____
Trouble staying Asleep	____	_____	_____	_____
Snoring	____	_____	_____	_____
Stomach Pains/Aches	____	_____	_____	_____
Infections	____	_____	_____	_____
Extreme Irritability	____	_____	_____	_____
Depression	____	_____	_____	_____
Panic Attacks	____	_____	_____	_____
Racing thoughts	____	_____	_____	_____
Body tension	____	_____	_____	_____
Can’t slow down	____	_____	_____	_____
Impulsivity	____	_____	_____	_____
Lack of motivation	____	_____	_____	_____
Obsessive Behavior	____	_____	_____	_____
Allergies	____	_____	_____	_____
Diabetes	____	_____	_____	_____
Thyroid Problems	____	_____	_____	_____
Motor or vocal tics	____	_____	_____	_____
Hyperactivity	____	_____	_____	_____
Anti-social behavior	____	_____	_____	_____

Stealing	____	_____	_____	_____
Phobias/Fears	____	_____	_____	_____
Suicidal thoughts	____	_____	_____	_____
Suicidal Actions	____	_____	_____	_____
Skin crawling sensation	____	_____	_____	_____
Fatigue, lack of Energy	____	_____	_____	_____
Memory problems	____	_____	_____	_____
Impulsivity	____	_____	_____	_____
Easily Frustrated	____	_____	_____	_____
Anger/rage	____	_____	_____	_____
Persistent worrying	____	_____	_____	_____
Poor handwriting	____	_____	_____	_____
Organization Difficulties	____	_____	_____	_____
Hyper talkative	____	_____	_____	_____
Hyper focus	____	_____	_____	_____
Poor Attention	____	_____	_____	_____
Spaciness	____	_____	_____	_____
Confused thinking	____	_____	_____	_____
Disorientation	____	_____	_____	_____
Difficulty following Steps	____	_____	_____	_____
Asthma	____	_____	_____	_____
Eating Disorders Obesity	____	_____	_____	_____

Addictions	____	_____	_____	_____
L-handed or ambidextrous	____	_____	_____	_____
Seasonal mood/ behavior changes	____	_____	_____	_____
Sleep walking	____	_____	_____	_____
White spots on nails	____	_____	_____	_____
Head Injuries	____	_____	_____	_____

Has the child/adolescent been diagnosed with any medical/physical/emotional/psychological conditions. If so, what diagnoses, when, and by whom?

Please list all medications, nutritional supplements taken including allergy shots, inhalers, vitamins/minerals, herbs. Please note any bad reactions or no effect for these drugs, etc.

	For Condition	**Dose**	**Dates of Usage**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL TREATMENT (surgery or hospitalization, recurrent illness)

Description, condition	Date

PSYCHOLOGICAL TREATMENT (psychologist, counselor, social worker, family therapist)

Description, condition	Date

EDUCATIONAL THERAPY (educational therapist, tutor, special school, resource teacher, vision therapy, etc.)

Description, condition	Date

_____ _____

_____ _____

_____ _____

DEVELOPMENTAL MILESTONES

First Tooth _____ Walking with Help _____

Sitting up _____ Walking unaided _____

Crawling _____ Running _____

Toilet Training began at _____ Training completed at _____

Mama/dada spoken _____ Four/five word phrases _____

Full sentences _____ Pronunciation clear _____

Tell time _____ Dress self _____

Tie shoelaces _____ Ride Bicycle _____

Signs of clumsiness in child/adolescent? Please explain.

Were there, or are there, any activities in which the child/adolescent was slow to develop compared with other children? Please explain.

Hearing difficulties? *(Details with dates)*

Speech difficulties? *(Details with dates)*

_____

_____

Reading difficulties? Explain. _____

Spelling difficulties? Explain. _____

Arithmetic difficulties? Explain. _____

NUTRITION/ENVIRONMENT HISTORY

Breast-fed from _____months to _____months

Bottle-fed from _____months to _____months

Solid food from _____ months

Has the child/adolescent ever been tested for lead poisoning? _____

Does or has the child/adolescent lived in an old house? _____

Were renovations done while residing in the house? _____

_____ Well-water _____ Septic tank _____ Copper piping _____ Township/City water

Does anyone in the household smoke? If so, who, where, and how much? _____

_____

Does the child/adolescent drink caffeinated beverages? _____ Glasses per day _____
Eat foods with aspartame (Nutrasweet) _____ per day _____

Food cravings _____

_____

Food sensitivities/allergies _____

_____

Food aversions/dislikes_____

_____

PARENTAL SEPARATION

Were parent and child/adolescent ever separated from each other for longer than one week during the first four years of the child's life? Please check list below and give details and indicate which parent.

	Details/for how long?	Age of child Yrs	Mos
Parent in hospital?	_____	___	___
Child in hospital?	_____	___	___
Holiday separation?	_____	___	___
Business separation?	_____	___	___
Other separation?	_____	___	___

Brief details of separations listed above (Who looked after child/adolescent, where did he/she stay, etc.)

Did mother work at all during first four years of child's life?_____

Details, if any. (Part-time, full-time, etc.)_____

_____

Were there any other emotional/mental difficulties that strained the parent/child relationship. Please describe.

ACTIVITIES Please list any regular activities or interests of the child/adolescent including the frequency of involvement. Please include extracurricular school activities, religious and civic organizations, sports or other physical activities, hobbies, general interests, or special talents. Please include how the child generally spends his/her leisure time.

Please describe child/adolescent's major strengths

Please describe child/adolescent's major weaknesses

Please describe child/adolescent's major complaints

SOCIAL/PEER RELATIONSHIPS

Does the child/adolescent have one or more close friends? _____

Does the he/she make friends easily? _____

Does he/she tend to keep them? _____

Has he/she ever been/is currently teased or bullied? Explain. _____

_____

Rate the degree to which the child/adolescent feels comfortable and relaxed in social situations.

____ Very relaxed ____ Somewhat comfortable _____ Somewhat uncomfortable _____ very anxious

Does the child/adolescent have any major fears or anxieties? If so, explain. _____

_____

_____

Please describe who disciplines the child/adolescent and the method of discipline

_____

_____

_____

_____

Please describe the difficulties from which the child/adolescent suffers and for which you are seeking help. Include and behavioral problems at home or at school.

_____

_____

_____

_____

_____

_____

GOALS OF TREATMENT – Please briefly describe your goals for treatment.

_____

_____

_____

_____

_____

_____

ADOLESCENTS ONLY

Is the adolescent dating? _____ Since when? _____

To your knowledge, is he/she sexually active? _____

Any pregnancies? _____

Any children (name & age)? _____

Please explain any details if necessary. _____

_____

Has/Does adolescent use:

Substance	Current Frequency/Amount	Past Frequency/Amount
Alcohol	_____	_____
Cigarettes	_____	_____
Cola	_____	_____
Caffeine	_____	_____
Marijuana	_____	_____
Cocaine/Stimulants	_____	_____
Hallucinogens	_____	_____

Pain Killers	_____	_____
Tranquilizers	_____	_____
Sedatives	_____	_____
Other _____	_____	_____

EMPLOYMENT HISTORY

Is the adolescent currently working? _____

Employer Name _____ Occupation _____

Employer Address _____
(street) *(city, state, zip code)*

Work Phone: _____

Hours per week _____ Length of Employment _____

THANK YOU FOR COMPLETING THIS INFORMATION. WE TRULY APPRECIATE YOUR TIME AND EFFORT. ANY QUESTIONS, PLEASE CALL US. PLEASE FEEL FREE TO ADD ANY ADDITIONAL DOCUMENTATION, COMMENTS, ETC.