PSYCHIATRY AND WELLNESS OF GEORGIA

Child Intake form

DEMOGRAPHIC INFORMATION

Name:______________________________

Sex:______________________________

Date of Birth: ________________________

Guardian Name (if applicable):________________

Height:______________________________

Address:______________________________

Phone:______________________________

Preferred Pronouns:________________________

Weight:______________________________

EMERGENCY CONTACT INFORMATION

Name of emergency contact: ____________________

Relationship: ____________________________

Phone: ______________________________

Please list below individuals with whom your provider can discuss your care or release your psychiatric medical records.

Release of Information (ROI): Name:____________________ Relationship:____________________________

If you do not want the provider to discuss your medical records, indicate. N/A

Yes ☐ *No* ☐ *N/A* ☐

Preferred Pharmacy:______________________________________

Insurance Name:__________________________ Copay amount:________________

Insurance ID#______________________ Group #______________________

Guarantor's name:______________________ Relation to patient: __________

Current Medication(s) / OTCs:	Dose:	Frequency:	Medication purposes:

Psychiatry and Wellness of Georgia

Initial Behavioral Health Intake Questionnaire

Today's Date: _________ Patient's Name: ______________________________ Date of Birth: ___________
Completed by: ______________________________ Relationship to Child: ■ Parent ■ Other ______________________
Doctor's Name: ______________________________ Child's Primary Care Provider (if different): ___________________

Note: Substitute "you" for "your child" if completed by an adolescent or teenager.

1. **What are your main concerns about what your child is dealing with at this time?** ________________
   Physical: ______________________________
   Emotional: ______________________________

2. **What are your current symptoms, and how long have you had them?** ______________________________

3. **What is currently causing you stress (at home, school, or work; in relationships)?**

4. **Have you been treated for medical problems in the past?** Complete the table below. Include any type of outpatient or inpatient treatment or therapy your child received. **Be sure to list all medicines that your child has taken.**

Type of illness or concern?	**When** did you seek help?	**What treatment** did your child receive (medicine, counseling)?	If treatment included **medicine**, list the name, number of "mg" from the pill bottle label, and how often (daily, with meals, etc.).	Did it help? **(Yes or No)**?	Were there side effects? **(Yes or No)** **What kind?** (Use back of page if you need more space.)
Mental Health Problems					
Other Medical Problems					

5. **Do you have problems sleeping? If yes, answer the following:**

Where does your child sleep?________________________ How long has your child had sleep problems?__________

On average, how many nights per week do you have sleep problems?___

Which of the following best describes your child's sleep pattern:

☐ Has trouble falling asleep.

☐ Wakes up frequently at night.

How bad would you say your sleep problem is?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Not present		A little bad			Pretty bad		Very bad			Couldn't be worse

6. **Abuse and traumatic events:** Check any events below that you have experienced in the past **OR** that are going on now.

☐ Physical abuse
☐ Emotional abuse
☐ Sexual abuse
☐ Emotional neglect
☐ Physical neglect
☐ Traumatic events
☐ Drug abuse in the family

Now, answer the following questions about the items you checked above.

	Yes	No
Are any of the situations either occurring now or still affecting you?	◯	◯
Do you feel that you're in any danger or at risk because of any of these issues?	◯	◯
Have you sought help from a professional to deal with any of these issues?	◯	◯

If so, who?____

7. **Eating behaviors.**

Yes	No	
◯	◯	Are you concerned with your eating patterns?
◯	◯	Do you ever eat in secret?
◯	◯	Does your weight affect the way you feel about yourself?
◯	◯	Have any members of your family suffered from an eating disorder?

8. **Overall health.** How would you rate your overall health?

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Great		Ok			Not so good		Bad		Very bad	

Today's Date: __________ Patient's Name: ____ Date of Birth: ____________

9. **Have you experienced any of the following medical problems?**

Area of illness or concern (examples)	Age when first began?	Describe treatment received, if resolved or if still under treatment	Other comments?
Bones, Muscles (arthritis, joint pain, muscle aches)			
Ear, Nose, Throat (vision problems, hearing problems, ear infection, tubes in ears, speech problems)			
Endocrine (diabetes, metabolic syndrome, thyroid problems, menstruation problems)			
Heart, Blood Vessels (heart murmur, high blood pressure, high cholesterol)			
Lungs (asthma, allergies)			
Nervous System (headache, head injury, seizure)			
Stomach, Intestines (diarrhea, constipation, abdominal pain, vomiting)			
Urinary System (bladder or kidney infection, incontinence, bed wetting)			

10. **Have you been in a serious accident, been hospitalized, or had any surgeries? (Use back if more space needed.)**

List any:	Describe what happened	When did this happen?
Serious accidents:		
Hospitalizations:		
Surgeries:		

11. **Are you allergic to any medicines?** If so, please list the medicine and your reaction below:

____

____

12. **Are your immunizations current?** ▪ Yes ◯ ▪ No ◯

If not, which immunizations are **not** current? ____

Today's Date: ___________ Patient's Name: ____ Date of Birth: ______________

13. **Education.**

Current grade level: ___________ Name of school: ____

Are you satisfied with your performance in school? ◯ Yes ◯ No

If no, please describe:

____

____

Have you been suspended or expelled? ◯ Yes ◯ No

Do you receive special resources or services at school? ◯ Yes ◯ No

If yes, please describe: ____

____

14. **Other behaviors.**

Do you have any behaviors that concern you? ◯ Yes ◯ No

If yes, please describe:

____

____

Do your teachers or other adults in their life report behavior concerns? ◯ Yes ◯ No

If yes, please describe:

____

____

15. **Developmental history.**

Pregnancy. Were there any problems during pregnancy or delivery with this child? ◯ Yes ◯ No

If yes, please describe:

____

____

16. **Developmental history**

Childhood milestones. Has your child met all milestones? ____

17. **Lifestyle and family.**

Who do you live with? ____

If separated, divorced, or unmarried, please describe current custody and visitation arrangements:

____

Who are your primary caretakers at home?

____

Is anyone else routinely involved in the care of you?

◯ Family member ◯ Day care ◯ Neighbor ▪ Others: ______________________

Are you involved with DCFS, JJS, or other legal system? ◯ Yes ◯ No

If yes, please describe: ____

____

____

Psychiatry and Wellness of Georgia

Today's Date: ___________ Patient's Name: ____ Date of Birth: ______________

BIOLOGICAL FAMILY PSYCHIATRY HISTORY

	YES	NO	INDICATE FAMILY MEMBER
Sudden deaths (cardiac)			
Completed suicide			
Bipolar disorder			
Depression, Anxiety			
Schizophrenia/ Psychosis			
Seizures			
Addiction			
Any other			

Anxiety & Stress Disorder Symptom Rating Scale *(page 1 of 1)*

Today's Date: ______________ Patient's Name: ______________________________ Date of Birth: ______________

Completed by: ____________________ Relationship to patient: ☐ Self ☐ Parent ☐ Other: ____________________

The patient is currently: ☐ on medication for mood regulation ☐ not on medication ☐ not sure ☐ in counseling

Over the last 2 weeks, *how often have the problems below bothered you/your child? Circle a number for each item.*

	General Anxiety Disorder (GAD-7)	How Often			
		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious, or on edge?	0	1	2	3
	Not being able to stop or control worrying?	0	1	2	3
	Worrying too much about different things?	0	1	2	3
	Trouble relaxing?	0	1	2	3
	Being so restless that it is hard to sit still?	0	1	2	3
	Becoming easily annoyed or irritable?	0	1	2	3
	Feeling afraid as if something awful might happen?	0	1	2	3

Circle the number on the rating scale that corresponds to how much the symptoms below apply to you/your child.

	Other Symptoms	Rating Scale										
		Not at all	A little			Pretty much			Very much		Couldn't be worse	
2	**Panic:** This can include increased heart rate, increased blood pressure, chest pain or pressure, irregular breathing, getting lightheaded	0	1	2	3	4	5	6	7	8	9	10
3	**Physical symptoms:** This can include stomachache, headache, tight muscles, shaking, muscle twitching, sweats	0	1	2	3	4	5	6	7	8	9	10
4	**Obsessions and/or compulsions:** This can include repeated or persistent thoughts that they can't control (about germs, schoolwork, being perfect, neatness, safety, death); repeated behaviors or extreme routines that they can't control (such as repeated handwashing, checking locks, cleaning, personal hygiene)	0	1	2	3	4	5	6	7	8	9	10
5	**Post-traumatic stress:** This can include repeated, disturbing thoughts or dreams about a traumatic experience from the past, having physical reactions when reminded of the traumatic experience, avoiding situations that are reminders of the experience, feeling distant or emotionally numb, feeling jumpy or easily startled Check if post-traumatic symptoms have lasted **more than 4 weeks:** ☐	0	1	2	3	4	5	6	7	8	9	10
6	**Hallucinations:** This can include hearing voices or seeing things that others don't hear or see.	0	1	2	3	4	5	6	7	8	9	10

Symptom duration: Symptoms have been of serious concern for (circle the appropriate time period):

☐ 2 to 4 weeks ☐ 1 to 3 months ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1 to 2 years ☐ More than 2 years

Have 2 or more of these symptoms lasted longer than 1 year? ☐ Yes ☐ No

For office use only: GAD-7 score (item 1): ______ / 21 Other symptoms (Q 2–5): ______ /40 Hallucinations (Q 6): ______ /10

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Patient and Provider Publications 801-442-2963 MHI013 - 10/14

MHI Pack 50402

Patient Health Questionnaire (PHQ-C) *(page 1 of 1)*

Today's Date: ______________ Patient's Name: ______________________________ Date of Birth: ______________

Is your child currently: ■ on medication for depression ■ not on medication for depression ■ not sure ■ in counseling

Over the last 2 weeks, how often has your child been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, irritable, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about him or herself, — or that he or she is a failure or have let him or herself or family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading, or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed, or the opposite — being so fidgety or restless that he or she has been moving around a lot more than usual	0	1	2	3
9. Thoughts that he or she would be better off dead, or of hurting him or herself in some way	0	1	2	3
Total each column				

10. If your child is experiencing any of the problems on this form, how difficult have these problems made it for your child to do his or her work, take care of things at home, or get along with other people?

■ **Not difficult at all** ■ **Somewhat difficult** ■ **Very difficult** ■ **Extremely difficult**

11. In the **past year**, has your child seemed depressed or sad most days, even if he or she seems to feel okay sometimes?

■ **Yes** ■ **No**

For Office Use Only:

Symptom score (total # of answers in shaded areas): ___________

Severity score (total all points from all questions): ______________

Today's Date: Patient's Name:

Completed by: Relationship to Child: ■ Self ■ Parent ■ Other: Date of Birth:

Mark the box that corresponds to how much the described symptoms apply to your child.

#	Symptom		
1	Elevated Mood		Is your child's mood higher (better) than usual?
		■	0. No
		■	1. Mildly or possibly increased
		■	2. Definite elevation – more optimistic, self confident; cheerful; appropriate to their conversation
		■	3. Elevated but inappropriate to content; joking, mildly silly
		■	4. Euphoric; inappropriate laughter; singing/making noises; very silly
2	Increased Motor Activity/Energy		Does your child's energy level or motor activity appear to be greater than usual?
		■	0. No
		■	1. Mildly or possibly increased
		■	2. More animated; increased gesturing
		■	3. Energy is excessive
		■	4. Very excited; continuous hyperactivity; cannot be calmed
3	Sexual Interest		Is your child showing more than usual interest in sexual matters?
		■	0. No
		■	1. Mildly or possibly increased
		■	2. Definite increase when the topic arises
		■	3. Talks spontaneously about sexual matters; gives more detail than usual
		■	4. Has shown open sexual behavior – touching others or self inappropriately
4	Sleep		Has your child's sleep decreased lately?
		■	0. No
		■	1. Sleeping less than normal amount by up to 1 hour
		■	2. Sleeping less than normal amount by more than 1 hour
		■	3. Need for sleep appears decreased; less than 4 hours
		■	4. Denies need for sleep; has stayed up one night or more
5	Irritability		Has your child appeared irritable?
		■	0. No more than usual
		■	2. More grouchy or crabby
		■	4. Irritable openly several times throughout the day; recent episodes of anger with family, at school, or with friends
		■	6. Frequently irritable to point of being rude or withdrawn
		■	8. Hostile and uncooperative about all the time
6	Speech (Rate and Amount)		Is your child talking more quickly or more than usual?
		■	0. No change
		■	2. Seems more talkative
		■	4. Talking faster or more to say at times
		■	6. Talking more or faster to point he/she is difficult to interrupt
		■	8. Continuous speech; unable to interrupt

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Today's Date: ______________ Patient's Name: ____ Date of Birth: ______________

Mark the box that corresponds to how much the described symptoms apply to your child.

#	Item		Question / Response
7	**Language-Thought Disorder**		Has your child shown changes in his/her thought patterns?
		■	0. No
		■	1. Thinking faster; some decrease in concentration; talking "around the issue"
		■	2. Distractible; loses track of the point; changes topics frequently; thoughts racing
		■	3. Difficult to follow; goes from one idea to the next; topics do not relate; makes rhymes or repeats words
		■	4. Not understandable; he/she doesn't seem to make any sense
8	**Content**		Is your child talking about different things than usual?
		■	0. No
		■	2. He/she has new interests and is making more plans
		■	4. Making special projects; more religious or interested in God
		■	6. Thinks more of him/herself; believes he/she has special powers; believes he/she is receiving special messages
		■	8. Is hearing unreal noises/voices; detects odors no one else smells; feels unusual sensations; has unreal beliefs
9	**Disruptive/ Aggressive**		Has your child been more disruptive or aggressive?
		■	0. No; he/she is cooperative
		■	2. Sarcastic; loud; defensive
		■	4. More demanding; making threats
		■	6. Has threatened a family member or teacher; shouting; knocking over possessions/furniture or hitting a wall
		■	8. Has attacked family member, teacher, or peer; destroyed property; cannot be spoken to without violence
10	**Appearance**		Has your child's interest in his/her appearance changed recently?
		■	0. No
		■	1. A little less or more interest in grooming than usual
		■	2. Doesn't care about washing or changing clothes, or is changing clothes more than three times a day
		■	3. Very messy; needs to be supervised to finish dressing; applying makeup in overly-done or poor fashion
		■	4. Refuses to dress appropriately; wearing bizarre styles
11	**Insight**		Does your child think he/she needs help at this time?
		■	0. Yes; admits difficulties and wants treatment
		■	1. Believes there might be something wrong
		■	2. Admits behavior might have changed but denies need for help
		■	3. Admits possible change behavior, but denies illness
		■	4. Denies there have been any changes in his/her behavior/thinking

Total Score: ____/ 60

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DSM 5 ADHD Symptom Checklist

Name of child____ **Gender**______ **Age**______ **Date**_______________

Completed by: ____ **Telephone #** ________________________________

For each item below, circle the answer that best describes this child. 0=Not at all; 1=Just a Little; 2=Often; 3= Very Often					
Inattention Symptoms					
1.	fails to give attention to details or makes careless mistakes in schoolwork, work, or during other activities (e.g.,overlooks or misses details, work is inaccurate).	0	1	2	3
2.	has difficulty sustaining attention to tasks or play activities (e.g., has difficulty remaining focused during lectures; conversations; or lengthy reading).	0	1	2	3
3.	does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).	0	1	2	3
4.	does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked.	0	1	2	3
5.	has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized with work; has poor time management; fails to meet deadlines).	0	1	2	3
6.	avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).	0	1	2	3
7.	loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).	0	1	2	3
8.	Is easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).	0	1	2	3
9.	is forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).	0	1	2	3
Hyperactive Symptoms					
10.	fidgets with or taps hands or feet or squirms in seat	0	1	2	3
11.	leaves seat in situations in which it is inappropriate (NOTE: in adolescents or adults may be limited to feelings of restlessness).	0	1	2	3
12.	unable to play or engage in leisure activities quietly	0	1	2	3
13.	has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	is “on the go” or acts as if “driven by a motor” (e.g., is unable to be or uncomfortable being still for extended time in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with)	0	1	2	3
15.	talks excessively	0	1	2	3
Impulsive Symptoms					
16.	blurts out an answer before question has been completed (e.g., completes people’s sentences; cannot wait for turn in conversation).	0	1	2	3
17.	has difficulty waiting his or her turn (e.g., while waiting in line).	0	1	2	3
18.	interrupts or intrudes on others (eg, butts into conversations, games, or activities; may start using other people’s things without asking or receiving permission; for adolescents and adults may intrude into or take over what others are doing)	0	1	2	3
Approximately when did you first notice the behaviors that occur often or very often?					
Do these symptoms impair the person’s functioning in two or more settings? Yes No					
Where is there impairment? (circle all that apply) Home School Socially					

Reset Form

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing oz, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score = ____________________

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.
8: You have an average amount of daytime sleepiness.
0-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5.