**DATE:** _____

**CHILD'S NAME:** _____ **DATE OF BIRTH:** ___/___/___ **SEX:** ☐ Male ☐ Female

**CHILD LIVING WITH:** _____ **RELATIONSHIP TO CHILD:** _____

**LEGAL GUARDIAN:** _____ **RELATIONSHIP TO CHILD:** _____

**FAMILY INFORMATION** (list parents, caretakers, and sisters/brothers)

| | Name | Sex (M/F) | Age | Relationship | Occupation | Living with Child? |
|---|---|---|---|---|---|---|
| 1. | _____ | _____ | ___ | _____ | _____ | _____ |
| 2. | _____ | _____ | ___ | _____ | _____ | _____ |
| 3. | _____ | _____ | ___ | _____ | _____ | _____ |
| 4. | _____ | _____ | ___ | _____ | _____ | _____ |
| 5. | _____ | _____ | ___ | _____ | _____ | _____ |
| 6. | _____ | _____ | ___ | _____ | _____ | _____ |

**MEDICAL HISTORY**

Primary Care Doctor: _____ Address: _____ Phone: _____

Vaccinations up to date? ☐ Yes ☐ No

List any allergies to medications: _____

List medical problems (Current): _____

List medical problems (Past): _____

Current Medications (with dosages, if possible): _____

_____

**PREGNANCY**

Did mother have any health problems during pregnancy? ☐ Yes ☐ No If yes, list problems:

_____

_____

Did mother require medications during pregnancy? ☐ Yes ☐ No If yes, list medications:

_____

_____

Did mother use drugs or alcohol during pregnancy? ☐ Yes ☐ No If yes, list type:

_____

_____

Did mother smoke during pregnancy? ☐ Yes ☐ No

Patient Label

UCR HEALTH

**CHILD PSYCHIATRY INTAKE**

**LABOR/DELIVERY**

Gestation at deliver (How many weeks: _____ Type of Delivery: ☐ Vaginal ☐ C-Section

Any complications during labor/deliver (list):

_____

_____

Did baby require any special care or treatment? Please describe:

_____

_____

_____

**INFANCY/EARLY CHILDHOOD**

List any medical problems during this time:

_____

_____

Were any of the following a problem for your child during this time? (Mark those that apply)

☐ Did not enjoy cuddling?
☐ Did not calm when held/soothed?
☐ Did not adjust to sleep/wake cycle?
☐ Colicky
☐ Head banging?
☐ Biting self or other self-harm?
☐ Excessive activity level?
☐ Temper tantrums?

Developmental milestones: At what age did your child demonstrate the following? If you do not know exact age of child, please indicate if milestone occurred early or late.

| Milestone | Age of child | Early/Late | Comments |
|---|---|---|---|
| Smiled | _____ | _____ | _____ |
| Sat by self | _____ | _____ | _____ |
| Crawled | _____ | _____ | _____ |
| Walked | _____ | _____ | _____ |
| First words | _____ | _____ | _____ |
| Spoke sentences | _____ | _____ | _____ |
| Daytime bladder training | _____ | _____ | _____ |
| Nighttime bladder training | _____ | _____ | _____ |
| Daytime bowel training | _____ | _____ | _____ |
| Nighttime bowel training | _____ | _____ | _____ |

Were there any traumatic experiences in childhood? Please describe: _____

_____

## EDUCATIONAL HISTORY

Current school information

School name: _____ Grade: _____

City of School: _____ Phone #: _____

Teacher's Name: _____

Has your child received academic testing by school? ☐ Yes ☐ No

If yes, date of testing: _____ Reason for testing: _____

Outcome: _____

Are special education services being provided? ☐ Yes ☐ No If yes, what type: _____

_____

Is your child having problems in school now? ☐ Yes ☐ No If yes, describe: _____

Academic: _____

Behavioral: _____

Past school information

| | | |
|---|---|---|
| Preschool: | Attended? ☐ Yes ☐ No | Any problems (list): _____ |
| Kindergarten: | School name: _____ | Any problems (list): _____ |
| Elementary: | School name: _____ | Any problems (list): _____ |
| Junior High: | School name: _____ | Any problems (list): _____ |
| High School: | School name: _____ | Any problems (list): _____ |

## HISTORY OF CURRENT PROBLEMS

Please examine the following list and check any areas that concern you about your child:

| | | |
|---|---|---|
| ☐ abuse (physical/sexual) | ☐ activity level | ☐ aggression (fighting) |
| ☐ anxiety | ☐ alcohol/drug use | ☐ attention span |
| ☐ depression | ☐ eating problems | ☐ encopresis (soiling pants) |
| ☐ eneuresis (wetting pants) | ☐ fears/phobias | ☐ following rules |
| ☐ health problems | ☐ legal problems | ☐ obsessions/compulsions |
| ☐ psychosis | ☐ school problems | ☐ sleep problems |
| ☐ situational stress | ☐ suicidal/homicidal thoughts | ☐ traumatic experience |

☐ other (list) _____

Please use your own words to describe the problems your child is experiencing:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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**Thank you for your assistance. When this form is complete, please return to the receptionist.**

Completed by/Reviewed by: _____