Manhattan Psychology Group, PC
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New York NY 10024
646-389-4112

Mental Health Intake Questionnaire: Child/Adolescent

Patient name:

Date of birth:

Age:

Address:

Which most closely describes the patient's gender?:

Sex assigned at birth:

Pronouns:

Race/Ethnicity:

Current school:

Current grade level:

Does the patient currently receive special education services?: ☐ Yes ☐ No

If yes, specify which special education services:

Emergency contact name/relationship:

Emergency contact's phone number:

Referred by name:

Referred by specialty:

Less Than 18 Years Old

If Patient is less that 18 years old, please provide the parents' or legal guardians' information below

Guardian 1 name:

Guardian 1 phone number(s):

Guardian 1 email address:

Guardian 2 name:

Guardian 2 phone number(s):

Guardian 2 email address:

Psychological Concerns and Treatment

Current Concerns

What is the primary concern?:

Is the patient currently receiving, or have they received, treatment for this concern within the past year?:

- [ ] Yes
- [ ] No

If yes, please check all other professionals seen for this concern within the past year (Check all that apply):

- [ ] Inpatient Treatment
- [ ] Therapist (outpatient mental health professional)
- [ ] Psychiatrist
- [ ] Developmental Pediatrician
- [ ] Neurologist
- [ ] School Counselor
- [ ] Other

If other, please list the type of professional seen:

Current Symptoms (Check all that apply):

- [ ] Feeling sad or down, extreme feelings of guilt or crying spells
- [ ] Confused thinking, reduced ability to concentrate, difficulty starting or completing tasks
- [ ] Excessive energy, hyperactivity, impulsivity or racing thoughts
- [ ] Excessive fears or worries or panic attacks
- [ ] Extreme mood changes or irritability
- [ ] Loss of interests or withdrawal from friends and activities
- [ ] Significant tiredness, low energy, fatigue or problems sleeping
- [ ] Detachment from reality, paranoia, suspiciousness or hallucinations
- [ ] Inability to cope with daily problems or stress
- [ ] Trouble understanding and relating to situations and to people
- [ ] Risky activity or substance (alcohol or drug) use
- [ ] Major changes in eating habits or appetite
- [ ] Excessive anger, hostility or violence
- [ ] Suicidal thinking, self-harm, intrusive thoughts of death or dying
- [ ] Other

Please explain other:

Please provide additional information about your current concern:

History of Psychological Treatment

Prior Psychiatric Evaluations?: Yes No

If yes, please provide the type/s of evaluation/s, the evaluator/agency, and date of evaluation/s:

Prior Psychological Diagnosis(es): Yes No

If yes, please provide the diagnosis/es, professional(s) that diagnosed, and the date(s) of diagnosis/es:

Prior Psychiatric Treatment?: Yes No

If yes, please provide the name of the treatment provider/agency, dates of treatment, and description of treatment:

Medical History

What medication(s) is the patient CURRENTLY prescribed (please include the name(s) of the medication(s), the dose(s), name(s) of prescriber(s), the date(s) the patient started it, and the reason for taking it)?:

What medications have been prescribed in the past year that are NO LONGER taken (please include the name(s) of the medication(s), the dose(s), name(s) of prescriber(s), the date(s) the patient started it, and the reason for taking it)?:

Please list any medical conditions that the patient is CURRENTLY being treated for:

Please list previous medical conditions that the patient is NO LONGER being treated for:

Please list any major surgeries (prior and pending):

Any other significant medical history?:

Family Structure and History

Who lives in the home (please include names, ages, and relation to patient)?:

Where did the patient grow up (city, state, and years residing in each)?:

Languages spoken in the home:

Who are the patient's primary caregivers?:

Guardian 1:

Guardian 2:

Childcare and afterschool programs:

Are the patient's parents still married?: Yes No

If no, how old was the patient when they separated?:

If no, did the patient's parents remarry?: ☐ Yes ☐ No

If yes, which parent(s), and how old was the patient when their parent(s) remarried?:

Family history of psychiatric difficulties; list relation to patient and diagnosis (i.e. brother - anxiety):

Substance Use and Sexual History

To your knowledge, has the patient ever tried the following: Alcohol, Tobacco, Marijuana, Illegal Drugs, Prescription Drugs (not prescribed), Sexual Activity (not including intercourse), Sexual Intercourse: ☐ Yes ☐ No

If yes, please check all that apply:

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Illegal Drugs
- ☐ Prescription Drugs (not prescribed)
- ☐ Sexual Activity (not including intercourse)
- ☐ Sexual Intercourse

If yes to any of the above, please provide additional information including dates and frequency:

Additional Information

Please feel free to provide any additional information that the patient would like the therapist to know.

Activities the patient enjoys:

Additional Information: