Kathryn Oliver, Psy.D

7600 East Arapahoe Road, Suite 305
Centennial, CO, 80112
303-856-5939

Intake Information

Today's date:

Client Information:

Name:
Date of Birth:

Name of Person completing this form:
Relationship to client:

Contacts:

Parent's name:
Contact Number:
Age:
Education level:
Occupation/hours per week:
Place of employment:

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Contact Number:
Age:
Education level:
Occupation/hours per week:
Place of employment:

Relationship Status of Parents:

Presenting Problem:

What concerns are you bringing your child in for? How has this concern affected their function at home/school/in their community?

When did you first notice this concern?

Do you have other concerns you want addressed?

What are your goals/expectations for treatment? What are your child's goals?

Symptoms and Behaviors of concern

Please circle all items relevant to your child:

DEPRESSIVE SYMPTOMS- sad, irritable, hopeless, poor sleep, crying, social withdrawal/isolative behaviors, lack of interest in previously enjoyed activities

MOOD SWINGS- energetic, little sleep, excessive pleasure seeking, racing thoughts, too talkative, grandiosity, quick transition from happy to sad or angry

ANXIOUS SYMPTOMS- worries, restless, scared, poor sleep, obsessive thoughts and/or compulsive behaviors, frequent complaining of headaches and/or stomach aches, frequent school absences/school refusal, panic attacks, skin picking

AGGRESSION- fights, excessive anger, excessive arguing, truancy, destruction of property, fire setting, difficulty with authority, manipulation of others

ATTENTION/HYPERACTIVITY- difficulty sustaining attention, hyperactive, impulsive, distractibility, not completing tasks, daydreaming too much, concerning grades

ABNORMAL EATING BEHAVIORS-too much, too little, fear of weight gain, distorted body image, over exercising, non-allergenic food sensitivities or restricted food acceptance

SOCIAL ANXIETY- shy and/or afraid to be around others, fears of public speaking or other display in front of a group

PAST TRAUMAS- frequent nightmares, intrusive and/or recurrent memories, hypervigilance, irritability/quick temper, mis-identifying scale of negative interactions

AUTISM- social and language impairments, rigidity, stimming or repetitive behaviors when stressed, especially for girls- frequent feelings fatigue due to masking or acting “normal” to fit in

PSYCHOSIS- hearing voices or seeing things that are not there and don’t fit the religion or culture of the child, paranoia, delusions

DISSOCIATION- feeling outside their body or things are not real

ATTACHMENT CONCERNS- indifference to parents, social or familial relating difficulties, quick transitions from “hot to cold”, history of adoption, past neglect, parent with significant, untreated mental health concerns

TECH ISSUES- difficulty with limits when enforced, irritability after stopping, sneaking tech (games/phones) outside approved time, excessive concern with social media presence or followers, sexting, online bullying

Other symptoms not listed above:

Has your child ever harmed themselves intentionally? Attempted suicide? Harmed others?

Has your child been the victim to or a witness of abuse? If yes, please explain:

Past Psychiatric/Therapeutic History:
Please list any previous psychiatric treatment, hospitalizations, residential, or day treatment programs (including any alcohol and drug treatment programs):

Please list any current or prior psychiatrists and therapists your child has seen and for how long:

Please list this individual's current or past psychiatric medications, including dosage, frequency, response, and side effects:

Has there been evidence of any alcohol use/illegal drug use/abuse of prescription medications?

Family Mental Health History:
Consider this individual's immediate family, relatives on both sides (parents, siblings, aunts, uncles, grandparents, and 1st cousins)
Review the list below – if any relative has one of these disorders, check the disorder and describe their relation to your child (such as "Maternal Uncle") and their treatment history (if applicable).
* If this child lived with a caregiver other than a relative listed above that may have experienced on or more of the mental health concerns below, please include

Depression:
Anxiety:
Bipolar (manic depressive)I or II:
Schizophrenia:
Alcohol/Drug Problems:
Learning Disabilities:
Autism/Asperger/Pervasive Developmental Disorder:
Intellectual Disability (formerly Mental Retardation):
"Nervous Breakdown":
Psychiatric Hospitalizations:
Suicide (or attempts):
Panic Disorder:
PTSD (Post Traumatic Stress Disorder):
OCD (Obsessive Compulsive Disorder):
Seizures:
Migraines:
Other:

Family Events/Challenges/Stressors:
Please mark any current events/stressors experienced by your child's immediate family and/or historical events/stressors experienced by family members up to two generations removed:

Immigration to this country:
Cultural values systems conflicts:
Financial stress:
Loss of a family member:
Victim of crime:
Medical concerns of a family member:
Natural disaster:
Divorce:
Stressor not listed above:

If affirmative to any of these, please explain:

Family Structure:
Is your child your biological child? Yes No
If no, at what age was he/she adopted?
Is there any contact with their biological parent(s)?

Where was your child born and raised?
Has your child moved a number of times? Yes No
If yes, please list their age at time of move and location:

Has your child experienced any other family transitions or changes? Please explain:

Please describe the parent(s) relationship(s) with the child client:

Please list other children in the family and other household members who may also be living in your home (or other caregivers outside the home) and describe their relationship with your child:

Are you struggling with your marital relationship or parenting? If yes, please describe:

School History:
Your child's school and grade level:

What are typical grades?

What are your child's academic strengths and challenges?

Has there been a change in your child's performance at school? If yes, please describe:

Relationships with teachers?

Has your child received IQ or Academic testing? If yes, what were the results?

Does or has your child participate in Accelerated or Honors programs, IB or AP classes?

Does your child have a current or past Individual Education Plan (IEP)? If so, please describe:

If your child has been identified as gifted, what, if any, programs or pull-out classes are they participating in, based on this?

Has your child had problems with truancy, fighting, school refusal, absences, frequent detention, suspensions? If yes, please describe:

Peers:
Please describe your child's relationships and interactions with other children:

Does your child have opportunities for peer relationships outside of the school setting?

Culture:
What is the ethnic/cultural makeup of the family?

Do you have a religious preference in the household?
If yes, what is that preference?

Has your child or members of the immediate family experienced any problems related to race, religion, or culture?
If yes, please explain:

Medical History:
Primary Care Provider:
Phone:
Address:
Approximate Date of Last Visit:
Number of Visits in Last Year:

Other Provider(s) of medical services:
Name:
Phone:
Address:
Specialty:

Allergies (drug, food, seasonal, environmental etc.)? Yes No If yes, please name and describe your child's reaction:

Please list the patient's current non-psychiatric medications, including dosage, frequency, and response:

Has your child ever experienced a head injury, loss of consciousness, or seizure?
If yes, please describe:

Does your child have any chronic medical problems?
If yes, please describe:

Does your child have a history of any serious injuries or medical hospitalizations? If yes, please describe:

Does your child have chronic pain (frequent headaches, stomachaches, chest pain)? If yes, please describe:

Sleep Patterns:
Total hours of sleep per night:
Usual Schedule: _____ to _____
Does the individual take naps during the day? Yes No
If Yes, how many hours in a typical day?

Concerns:	Current Problem	Change within last 6 months
Difficulty falling asleep:	Yes No	Yes No
Frequent awakening:	Yes No	Yes No
Snoring:	Yes No	Yes No
Restlessness/Movements:	Yes No	Yes No
Early morning awakening:	Yes No	Yes No
Nightmares:	Yes No	Yes No
Not rested:	Yes No	Yes No

If yes to any of the concerns listed above, please describe:

Have you recently worried that your child may have problems with:
Heart
Constipation/Diarrhea/Digestive system
Lungs
Frequent or extensive infections
Kidneys/Bladder
Endocrine (i.e., diabetes; thyroid dysregulation; excessive hair growth)
Neurological (i.e. concussion, head trauma, changes in cognition)
Hormonal imbalances/sex development concerns

Immunizations up to date?

Has your child ever had an EEG, MRI, CT SCAN, etc?
If yes, why was it done and were the results normal?
If yes, where were the tests performed and who ordered them?

For females:
Age of first menses
Regular or Irregular cycle?

Developmental History:

Did your child achieve the following milestones early (E), average (A), or late (L) compared with others his/her age (please explain if late):

Language (age at first using words, sentences, etc…)? E/A/L
Fine motor skills (building towers with cubes, drawing circle) E/A/L
Gross motor skills (rolling over, standing, walking)? E/A/L
Toilet training? E/A/L
Ability to self-soothe? E/A/L
First friend? E/A/L

Has your child experienced any regression of these? Yes/No If yes, explain:

Has your child had any illnesses or experiences that affected development?

Pregnancy and Birth History:

How old was this child's biological parents when he/she was conceived?
M: F:
Was this the biological mother's first pregnancy? Yes No
If no, how many times was she pregnant before this pregnancy?
Did the biological mother have any miscarriages before or after this pregnancy?
If yes, how many? During what trimester?
When was prenatal care first received (in weeks):
Baby's birth weight and length:
Length of pregnancy (in weeks):

Please indicate whether any of the following events/problems occurred during this pregnancy. Please include the trimester in which the event occurred, as well as any other important details:
Infections/Colds:
Fevers:
Hospitalizations:
Vaginal Bleeding, Spotting:
Problems with Diet:
Pregnancy Induced Hypertension:
High Blood Pressure, Excessive Swelling:
Diabetes:
Rh or Blood Incompatibilities:
Trauma (Emotional Stress and/or Physical Injury):
Did the mother take any medications (prescription and over the counter) during this pregnancy? (include name, # of months used, dosage, reason)

Did the mother consume alcohol during this pregnancy?
If yes, how much and how often?
Did the mother smoke or use tobacco products during this pregnancy?
If yes, please describe how much and how often?
Did the mother use any drugs during this pregnancy?
If yes, please name drug(s), how much and frequency of use:

Labor Information:
Type of delivery (c-section, vaginal):
Length of labor:
Were forceps used?
Any problems with the baby's health right before or immediately after delivery?
If yes, please describe:
Were the mother and baby separated after birth for more than 24 hours at a time?
If yes, please explain:

How does your child handle challenges?

What are your child's interests and favorite activities?

What are your child’s strengths?

Is there anything else you would like me to know about your child?