Thank you for trusting us.

All Star Pediatrics East Louisville Pediatrics Oldham County Pediatrics
Prospect Pediatrics South Louisville Pediatrics Springs Pediatrics

Dear Parent or Guardian,

My name is Dr. Shannon Williams and I am a Psychiatric/Mental Health Nurse Practitioner (PMHNP). I am glad to be partnering with your child's pediatric primary care provider to address his or her behavioral health needs.

I understand that you and/or your child may be nervous about our appointment. That is okay! I am here to meet your child exactly where they are and create an environment that is safe, compassionate, and judgment-free.

Please complete the attached forms as thoroughly as you are able and return them ***prior*** to your appointment. I understand there are a lot of questions, some of which you have probably already discussed with your doctor, but the information you provide will greatly assist me in identifying your child's needs and how to best serve your family.

I look forward to meeting you!

Sincerely,

SWilliams

Dr. Shannon Williams, DNP, APRN, PMHNP-BC

Behavioral Health Intake Form

Date: __ /__ /__

Person completing form: _______________________

Relationship to child: _____________________

Child's Full Legal Name: ________________________

Preferred Name: _____________________________

Address: _____________________________________

Phone Number: _____________________________

DEMOGRAPHICS

Household Composition

Who lives in the primary residence with the child?			
Name	**Sex**	**Age**	**Relationship to Child**

Parents Marital Status

Never married

Married/Civil Union

Separated, when_____

Divorced, when______

Widowed, when______

Remarried, when____

Is the child adopted:

No

Yes *IF YES, is the child aware? No____ YES_____

What are the main concerns that you have about your child?

How long have you had these concerns?

What are your goals for treatment of your child?

Please list any cultural or religious preferences that you would like for me to know about?

PAST PSYCHIATRIC HISTORY

Has your child ever seen a psychiatrist or therapist before?

NO

YES *IF YES, please complete the following:

Name of Provider	**Dates Seen**	**Reason**

Has your child ever taken any psychiatric medications?

NO

YES *IF YES, please list the medications

Has your child ever been admitted to a psychiatric hospital?

NO

YES *IF YES, please complete the following:

Name of Hospital	Dates	Reason

Has your child ever attempted suicide?

NO

YES *IF YES, please describe:

Does your child engage in any self-harm behaviors (cutting)?

NO

YES *IF YES, please describe:

Has your child ever been violent or aggressive?

NO

YES* IF YES, please describe:

FAMILY HISTORY

Does the child have any blood relatives with heart problems (i.e. defects, arrhythmias)?

NO

YES

Does the child have any blood relatives who died at a sudden age?

NO

YES

SUBSTANCE USE HISTORY

Please check if your child has ever used the following:

	NO	**YES (please specify)**
Alcohol		
Tobacco		
Illegal drugs		

MEDICAL HISTORY

Allergies:

Does your child have allergies to any of the following (*IF YES, please describe):

Medications?

NO

YES Describe:

Food allergies?

NO

YES Describe:

Environmental allergies?

NO

YES Describe:

Medical Conditions:

Does your child have any history of the following medical conditions (*check all that apply*)?

Condition	**NO**	**YES**
Asthma		
Respiratory Illness		
Diabetes		
Convulsions/Seizures/Epilepsy		
Head Injury		
Dizziness or Fainting		
Loss of Consciousness		
Heart problems		
High Blood Pressure		
Low Blood Pressure		
Urogenital Problems		
Vision Problems		
Hearing Problems		

Any other serious illness or disease? ______________________________________

Has your child ever been hospitalized for any medical condition?

NO

YES *IF YES, please describe and give dates:

Has your child ever had surgery?

NO

YES*IF YES, please describe and give dates:

Has your child ever had any serious injuries?
NO
YES *IF YES, please describe and give dates:

Biological Females only:

Has your child started menstruation?
NO_____
YES____
*IF YES:
at what age_________
Are periods regular?
NO
YES
Last menstrual cycle? _____/_____/_______
Is there any change in symptom severity with periods?
NO
YES

MEDICATIONS

Is your child ***currently*** taking any medications? NO_____ YES_____
*IF YES, please list all ***current*** medications your child is currently taking:

Name of medication	Dose and frequency of medication	Who prescribes it?

Is your child currently taking any ***psychiatric*** medications?
No
Yes *IF YES, please list the medications

Is your child taking any supplements or vitamins?
NO

YES *IF YES, please describe:

Educational History

Name of child's current school: ____________________________________
Current grade: _____________
Did the child repeat any grades? NO YES
Does the child have a 504 plan or IEP? NO YES
Is the child in ESE or special needs classes? NO YES
Has the child ever been suspended or expelled? NO YES

Activity

<table>
<tr><td colspan="3">Approximately how many hours a day of screen time does your child have? (i.e computer, television, i-pad, videogames?</td></tr>
<tr><td colspan="3">Approximately how many hours a day does your child spend completing homework?</td></tr>
<tr><td>Approximately what time does your child go to bed at night?
_________</td><td>Wake up time:
_____________</td><td># of hours slept
______________</td></tr>
<tr><td colspan="3">Please describe your child's strengths:</td></tr>
</table>

Please *CHECK* if your child has experienced any of the following? *

Death of parent

Death of other loved ones/close friend

Death of a pet

Separation from parent or family

Parent separation/divorce

Loss of home

Family financial problems

Parent with substance abuse problems

Conflicts with parents

Removal of child from home

Victim of crime or violence

Unwanted pregnancy

Illness in family

Illness in self