Name _____
ID #: _____

BETTER MOOD CLINIC OF SOUTH GEORGIA, LLC.
CHILD MENTAL HEALTH CLINICAL INTAKE

Please answer all questions accurately so we can provide your child an optimal assessment, intervention and treatment plan.
How do you want us to refer to your child, or what name or pronoun would you like us to use in referring to them_____?

Section I: Your Child's Concerns and Stressors

What reasons led you to seek help today? _____
_____
Was there a recent event that made it important to seek treatment today? ___
_____
When did these concerns start; how long have they been occurring? _____
_____
Are the concerns or symptoms constant or intermittent? _____
What has been tried in the past to solve these concerns? _____
_____
Have you sought help for these concerns/symptoms in the past? _____
Was it helpful? Yes / No, Please explain_____
_____
Has your child been diagnosed with a psychological condition? Yes / No
If yes, please explain: _____
Has your child ever been hospitalized for psychological reasons? Yes / No
If yes, where and when? _____
Has your child been prescribed psychiatric medications? Yes / No
If yes, please list: _____
_____
How did these meds affect *y*our child? _____
Does anyone in your family have a psychological condition? Yes / No
If yes, how are they related to your child and what is their condition:_____
_____
What are your child's present stressors: _____
_____
Has your child experienced a significant life change(s) or event(s)? Yes / No
If yes, please explain:_____
What does your child do for leisure or fun? _____

Shaded Area is for Clinicians only:

Name _____
ID #: _____

Section II: Present Emotional State/ Psychiatric /Psychological Symptoms:

Is your child having or experienced:

- Extreme or sudden depressed mood Yes / No
- Loss of interest in pleasurable things Yes / No
- Increased guilt or disappointment in yourself Yes / No
- Change in energy Yes / No
  Has their energy level increased or decreased? _____
- Difficulty in focusing or concentrating Yes / No
- Change in appetite Yes / No
- If yes; has there been a weight loss or gain & how much? _____
- Feelings of being run down and lethargic Yes / No
- Change in sleep patterns Yes / No
  Has their sleep increased or decreased & how much? _____
- Mood swings Yes / No
- Rapid or pressured speech Yes / No
- Feelings of being keyed up or restless Yes / No
- Racing thoughts they can't stop Yes / No
- Engaging in impulsive or dangerous activities Yes / No
- Panic Attacks: If yes, how often _____ Yes / No
- Unusual or irrational fears. If yes, please explain Yes / No
  _____
- Repetitive thoughts (obsessions) Yes / No
- Hearing or seeing things that others do not Yes / No
- Beliefs that others are trying to harm/control them Yes / No
  If yes, who? _____
- Isolating from people and wanting to isolate him/herself Yes / No
- Traumatic event (ex., deployment, rape, abuse, hurricanes…) Yes / No
- If yes, please describe: _____
- Unexplained Losses of time: If yes: how often? _____ Yes / No
- Emotional numbing / Absence of feelings Yes / No
- Flashbacks or intrusive memories Yes / No
- Frequent nightmares, night terrors or sleepwalking Yes / No
- Body image problems Yes / No
- Eating uncontrollably or not much at all Yes / No
- Chronic physical discomfort Yes / No
- Behavioral problems: breaking things or hitting someone? Yes / No
- If yes, what happened? Was your child arrested? _____

Name _____
ID #: _____

Section III: Social History / Early Development:

Where was your child born and raised? _____
Where does your child's extended family reside? _____
How many brothers or sisters does your child have? _____
Are there significant events in your family? (Ex. adoption, divorces, unwed, transgender parents…) Please describe:_____
Describe your current living situation? _____
Race/Ethnicity (circle all that apply): Caucasian or white American / African or African - American / Asian or Asian – American / Hispanic / British German / Italian / Filipino / Korean / Mixed / Other _____
Are you experiencing any interracial / intercultural or blended family concerns: If yes, please describe:_____

Were there any complications in the birth of your child? Ex. Premature….
If yes, please describe: _____
Were there delays in developmental milestones? Ex: Walking, toilet training, feeding, speech: _____ _____
_____
Does your child have any coordination problems? Ex. Tying shoes, riding a bike, jump rope, writing their name, etc: _____
Does your child tend to play alone or have difficulties with peers? _____
_____
Does your child resist being held or touched? _____
Does your child engage in eye contact / reciprocal communication? _____
Does your child sleep with another family member? _____
Does your child have any unusual bonds to foods, toys, objects? _____
Does your child have difficulty with change? _____
What grade is your child in? _____
What were their recent qtr/semester grades? _____
What school does your child attend? _____ _____
Is your child in any special education or gifted classes? _____
Does your child belong to any groups, churches or organizations? If yes, please list:_____
Do you have any cultural/religious beliefs that shape your child's life (for better or worse) If yes, please describe: _____

Section IV: Self - Stimulation / Self - Harm:

Does your child engage in self-stimulation? Yes / No
If yes, what kind of behavior? _____
Has your child ever cut, hit or burned him/herself on purpose? Yes / No
Has your child expressed a desire not to be alive? Yes / No
Has your child expressed thoughts to hurt him/her self or another? Yes / No
If yes to any of the above, please describe: _____
Are you afraid to leave your child alone? _____
Is your child having any of these thoughts right now? Yes / No
If yes, please explain. _____

Section V: Substance Abuse / Repetitive Behaviors:

Does your child use tobacco? Yes / No

- If yes, how many packs/cartons per day? _____

Does your child drink alcohol? If yes, answer the following questions?

- How much and how often? _____
- Have they experienced blackouts or have passed out? Yes / No

Have they tried to or wanted to stop smoking or drinking? Yes / No
If yes, what happened? _____

Does your child use marijuana, heroin, crack, cocaine or other street drugs?
If yes, please explain: _____
Do they misuse Oxycontin, Lortab, Vicadin or other prescribed medications?
If yes, please explain: _____

Has your child ever watched pornography? Yes / No
How much time does your child spend on the internet, Facebook, follow Twitter or play computer games in a given week? _____
Have they ever received treatment for any of the above behaviors? Yes / No
If yes, where and when? _____

Section VI: Child Strengths:

Please elaborate on your child's strengths: _____
_____
_____

Section VII: Legal / Medical:

Is anyone in the family experiencing any legal problems? Yes / No
If yes, please describe: _____
Have/ Is your family involved with the Department of Family and Children Services? If yes, please explain: _____

How would you describe your child's health? Poor / Good / Very Good
Are there any height or weight concerns: If yes, please describe _____
Are there any vision, hearing or eating problems? _____
Does your child have any food or medication allergies? _____
Does your child have any chronic or serious illnesses? _____
Does your child have a disability? If yes, please describe: _____
Does your child have a history of a head injury? _____
Has your child had any recent hospitalizations or surgeries? _____

Is your child experiencing gender identity or gender expression concerns?
If yes? Please explain: _____
Has your child gone through puberty? Yes / No
To the best of your knowledge is your child sexually active? Yes / No

Are there other problems not listed here that are affecting your child's ability to function? _____
_____

Treatment Goals (Please circle those that apply to your child):

Improve behaviors / manage anger better
Improve family relationships
Improve concentration and ability to focus
Reduce sadness / depression
Reduce nervousness / anxiety
Reduce stress / racing thoughts
Stop recurrent / ongoing thoughts or behaviors
Stop addictive behaviors
Other:

Signature of Patient/ Guardian: **Date:**	**BMC of SGA Provider:** **Date:**