Brianna Fava, Ph.D.

CHILD AND ADOLESCENT INTAKE PACKET

Today's date: ______ /______ /______

Child's Name: ____________________________ Date of Birth ______ /______ /______ Age: ____________

Mother's Name: ______________________________ Father's Name: ________________________________

Step- Mother's Name: ________________________ Step- Father's Name: ___________________________

Legal Guardian's Name: *(if applicable)*: ____

CONTACT INFORMATION

Address: ____

City: _______________________________________ State: ________________ Zip: _____________

Email: ____

Child's Cell: (________)______________________ Home: (________)____________________________

Mother's Cell: (________)______________________ Father's Cell: (________)______________________

Mother's Work: (________)_____________________ Father's Work: (________)_____________________

School Name: ____ Grade: ______________

School Address: ____

School Phone: (________)___________________________

School Fax: (________)___________________________

If applicable to presenting concern:

School Psychologist/Guidance Counselor's Name: _______________________________________

Phone: (________)______________________ E-Mail: _______________________________________

Teacher(s) Name(s): ____

Phone: (________)______________________ E-Mail: _______________________________________

If your child is in Special Education, please specify: ____

Primary Care Physician: ________________________________ Phone: (________)____________________

Referred to see Brianna Fava, Ph.D. by: ____

CHILD AND ADOLESCENT INTAKE PACKET

FAMILY INFORMATION

Please list all individuals who are currently living in the child's **primary** residence:

Name	Relationship to Child	Age

If applicable, please list all individuals who are currently living in the child's **secondary** residence:

Name	Relationship to Child	Age

Child's parents are: *(Circle one)* Single / Married / Separated / Divorced / Widowed / Cohabitating

Mother's Occupation: ______________________________ Father's Occupation: ______________________________

Step-Mother's Occupation: _________________________ Step- Father's Occupation: _________________________

Have there been any deaths of or separations from parents, family members, nannies, babysitters, or friends with whom patient was close or had frequent contact? *(Circle one)* **YES** / **NO**

If yes, please explain and include dates of separation/loss and relationship to child:

____
____
____
____

Have any family members had emotional or psychiatric problems? *(Circle one)* **YES** / **NO**

If yes, please indicate who? What was the nature of their difficulties? Was treatment sought?

____
____
____
____

CHILD AND ADOLESCENT INTAKE PACKET

DEVELOPMENTAL HISTORY

Pregnancy/Delivery/Developmental History:
(If your child was adopted, please fill out the information as best you can and go to the next page.)

Please list any complications the child's mother had during pregnancy or delivery:

____
____
____
____

Child was born *(Circle one):*

PRE-TERM By # _______ days   ON-TIME   POST-TERM By # _______ days

At what age did your child achieve these developmental milestones?

CRAWLING: _______________ WALKING: _____________ TALKING (single words): _____________

TALKING (sentences): _____________ TOILET TRAINING: _____________ READING: _____________

Did you have any concerns regarding your child's development from ages 0 to 5 years old?

EXCESSIVE CRYING: Y / N   HYPERACTIVITY: Y / N   SPEECH: Y / N

FEEDING PROBLEMS: Y / N   SLEEP: Y / N   HEARING: Y / N

MOVEMENT: Y / N   SOCIAL RELATEDNESS: Y / N   VISION: Y / N

*If you answered **yes** to any of the items above, please describe:*

____
____
____
____

Please provide any other important information about your child's development that you feel is important:

____
____
____
____

CHILD AND ADOLESCENT INTAKE PACKET

ADOPTION HISTORY *(Please skip page if not applicable)*

At what **age** was your child given up for adoption? _________

What **country** was your child born in? ________________________________

Where did your child live before he/she came to live with you (e.g., orphanage, biological parents, biological family members, foster care)? What were the conditions like in the child's previous home(s)?

____
____
____

What does your child know about his/her biological parents? ________________________
____
____
____

What information about his/her biological parents or the circumstances of his/her adoption have you kept from your adopted child out of concern for its impact on his/her well-being?

____
____
____

Does your child have other biological full or half-siblings *(Circle One)* Y / N

If yes, do you or your child know their whereabouts? ______________________________
____
____

Please discuss the circumstance surrounding your (and your spouse/partner's) decision to adopt a child:

____
____
____
____

Does your adopted child evidence any of the following behaviors? *(Please circle)*:

RUNNING AWAY	EXCESSIVE CLINGING	SEXUALIZED BEHAVIORS	AGGRESSIVE BEHAVIORS
DIFFICULTY WITH SLEEP OR BEDTIME	DIFFICULTY RELATING TO PEERS	PHYSICAL DEVELOPMENTAL DELAYS	LYING OR STEALING

CHILD AND ADOLESCENT INTAKE PACKET

MEDICAL HISTORY

Please list your child's medical problems *(from infancy to present time):*

____

____

____

Hospitalizations / Surgeries:

Dates — Reason for Hospitalization / Surgery

_________________ _______________________________________

_________________ _______________________________________

Current Medications for Medical Issues:

Rx Name: _______________ Dosage: ________mg Start Date: ____ /____ /____

Rx Name: _______________ Dosage: ________mg Start Date: ____ /____ /____

Rx Name: _______________ Dosage: ________mg Start Date: ____ /____ /____

PSYCHOSOCIAL TREATMENT HISTORY

Has your child ever had psychological / psychiatric treatment of any kind? *(Circle One)* Y / N *If yes, please detail below:*

MODE OF TREATMENT	DATES	REASON FOR TREATMENT
OUTPATIENT		
Individual		
Family		
Group		
Other		
INPATIENT		
Hospitalization		

Is your child currently taking medication for a psychiatric problem? *(Circle One)* YES / NO

If yes, please list the name, address, and telephone number of his/her prescribing psychiatrist:

Name: ____

Address: ____

City: ______________________ State: ________ Zip: ____________

Office: (_____)____________ Email: ______________________

If yes, please list the names, dosage, and dates of each of his/her medications:

Rx Name: _______________ Dosage: ________mg Start Date: ____ /____ /____

Rx Name: _______________ Dosage: ________mg Start Date: ____ /____ /____

CHILD AND ADOLESCENT INTAKE PACKET

REASON FOR REFERRAL

Please circle the issues or symptoms you are currently concerned about with respect to your child/adolescent:

SAD/DEPRESSED MOOD	SLEEP DISTURBANCES	HEARING VOICES
WORRIES/ANXIETY	NIGHTMARES	SEEING THINGS OTHERS DON'T SEE
WITHDRAWN	POOR ATTENTION/ CONCENTRATION	INNAPROPRIATE SEXUAL BEHAVIOR
IRRITABLE	HYPERACTIVITY	SHYNESS
PHYSICAL AGGRESSION/ FIGHTING	ACADEMIC PERFORMANCE	SOCIAL SKILLS
DECREASED/INCREASED APPETITE	SCHOOL ATTENDANCE	VICTIM OF BULLING
RESTRICTIVE EATING/ BINGING OR PURGING	OPPOSITIONAL/ DEFIANT TOWARDS ADULTS	CONFLICTS IN FAMILY RELATIONSHIPS
BEREAVEMENT	STEALING/LYING	ALCOHOL/DRUG USE
TRAUMA	SELF-INJURIOUS BEHAVIOR (e.g., Cutting)	WETTING/SOILING BED OR PANTS
PARENTAL DIVORCE/ SEPARATION	SUICIDAL THOUGHTS	REPETITIVE BEHAVIORS (e.g., Hand Washing)

Please elaborate on the reasons circled above and describe why you are seeking treatment for your child/adolescent:

____

____

____

When did these difficulties begin? Did any specific event occur prior to them beginning?

____

____

____

Does your child/adolescent agree with your understanding of the presenting issue(s) *(Circle One)* Y / N

If no, please describe how your child/adolescent views your current concerns:

____

____

____

Please use the back of this page or attach additional pages to describe any other issues, questions, or concerns you have about your child or adolescent.