Child and Adolescent Initial Psychiatric Evaluation Form

Patient Information

Name: _____ Date of Birth: __ Date: _ Age: _ Gender: _ Grade in School: _ MRN/ID: _ Parent/Guardian Name(s): _____ Relationship to Patient: _____ Provider: _____

Referral Information

Referred by: ☐ Self/Family ☐ Primary Care ☐ School ☐ Other: _____ **Reason for Referral: _____**

Chief Complaint (in patient/parent's own words)

History of Present Illness

Onset of symptoms: _____ Duration: _____ Context/Triggers: _____ Course: ☐ Improving ☐ Worsening ☐ Fluctuating ☐ Stable Severity: ☐ Mild ☐ Moderate ☐ Severe Associated symptoms: _____ Impact on functioning: - Academic: _____ **-** **Social:** _____ - Family: _____ **-** **Activities:** _____

Current Symptoms (check all that apply)

Mood/Emotional

☐ Depressed mood ☐ Irritability ☐ Mood swings ☐ Anxiety ☐ Fears/Phobias ☐ Excessive worry ☐ Panic attacks ☐ Separation anxiety ☐ Social anxiety ☐ Emotional dysregulation ☐ Low self-esteem ☐ Grief ☐ Other: _____

Behavioral

☐ Aggression ☐ Defiance ☐ Tantrums ☐ Impulsivity ☐ Hyperactivity ☐ Inattention ☐ Disorganization ☐ Stealing ☐ Lying ☐ Running away ☐ Self-injury ☐ Suicidal thoughts/ behaviors ☐ Homicidal thoughts ☐ Risky behaviors ☐ Substance use ☐ Other: _____

Cognitive/Perceptual

☐ Learning difficulties ☐ Poor concentration ☐ Memory problems ☐ Hallucinations ☐ Delusions ☐ Paranoia ☐ Dissociation ☐ Obsessive thoughts ☐ Compulsive behaviors ☐ Other: _____

Physical

☐ Sleep problems ☐ Appetite changes ☐ Weight changes ☐ Enuresis ☐ Encopresis ☐ Tics ☐ Headaches ☐ Stomachaches ☐ Fatigue ☐ Other: _____

Current Medications

Medication	Dose	Frequency	Start Date	Prescribed By	Effectiveness	Side Effects

Allergies

☐ No Known Drug Allergies ☐ Medication Allergies: _____ ☐ **Other Allergies:** _____

Past Psychiatric History

Previous Diagnoses: _____ **Previous Psychiatric Evaluations:** ☐ **No** ☐ **Yes:** _____ **Previous Psychiatric Hospitalizations:** ☐ **No** ☐ **Yes:** _____ **Previous Suicide Attempts:** ☐ No ☐ Yes: _____ **Previous Self-Harm:** ☐ **No** ☐ **Yes:** _____ **Previous Treatments: - Medications:** _____ - Therapy: _____ **- Other interventions:** _____

Developmental History

Pregnancy/Birth Complications: ☐ No ☐ Yes: _____ **Developmental Milestones:** ☐ On time ☐ Delayed: _____ **Early Temperament:** _____ **Attachment History:** _____

Developmental Concerns (check all that apply)

☐ Speech/Language ☐ Motor Skills ☐ Social Skills ☐ Toilet Training ☐ Feeding ☐ Sensory Issues ☐ Autism Spectrum ☐ Other: _____

Medical History

Primary Care Provider: _____ **Date of Last Physical Exam:** ___ **Current Medical Conditions:** _____ **Past Medical Conditions/Hospitalizations:** _____ **Significant Injuries/Surgeries:** _____ **Neurological History (seizures, head injuries, etc.):** _____ **Current Non-Psychiatric Medications:** _____

Family History

Family Psychiatric History: ☐ Depression ☐ Bipolar ☐ Anxiety ☐ ADHD ☐ Autism ☐ Schizophrenia ☐ Substance Use ☐ Suicide ☐ Other: _____ **Specific Family Members Affected:** _____

Family Medical History: _____

Social History

Family Composition: _____ **Living Situation:** _____ **Family Functioning:** ☐ **Supportive** ☐ **Conflictual** ☐ **Chaotic** ☐ **Other:** ___ **Significant Life Events/Trauma:** _____ **CPS Involvement:** ☐ **No** ☐ **Yes:** _____ **Legal Issues:** ☐ **No** ☐ **Yes:** _____

Educational History

Current School: _____ **Grade:** __ **Academic Performance:** ☐ **Above Average** ☐ **Average** ☐ **Below Average** ☐ **Failing Special Education Services:** ☐ **No** ☐ **Yes:** _____ **IEP/504 Plan:** ☐ **No** ☐ **Yes:** _____ **School Behavior Problems:** ☐ No ☐ Yes: _____ **School Attendance:** ☐ Regular ☐ Frequent Absences ☐ School Refusal

Substance Use History (if applicable)

Alcohol: ☐ None ☐ Current ☐ Past | Amount/Frequency: _____ **Tobacco/Vaping:** ☐ **None** ☐ **Current** ☐ **Past | Amount/Frequency: ___ Cannabis:** ☐ **None** ☐ **Current** ☐ **Past | Amount/Frequency: ____ Other Substances: _____**

Mental Status Examination

Appearance: ☐ Age-appropriate ☐ Younger than stated age ☐ Older than stated age ☐ Well-groomed ☐ Disheveled ☐ Other: _____

Behavior/Psychomotor Activity: ☐ Calm ☐ Agitated ☐ Restless ☐ Hyperactive ☐ Withdrawn ☐ Other: ___

Attitude toward Examiner: ☐ Cooperative ☐ Guarded ☐ Oppositional ☐ Shy ☐ Other: _____

Speech: ☐ Age-appropriate ☐ Delayed ☐ Normal rate/volume ☐ Pressured ☐ Minimal ☐ Other: _

Mood (self-reported): ☐ "Happy" ☐ "Sad" ☐ "Angry" ☐ "Worried" ☐ "Okay" ☐ Other: _____

Affect: ☐ Bright ☐ Restricted ☐ Blunted ☐ Labile ☐ Congruent ☐ Incongruent ☐ Other: ____

Thought Process: ☐ Age-appropriate ☐ Linear ☐ Tangential ☐ Disorganized ☐ Other: ___

Thought Content: ☐ Age-appropriate ☐ No SI/HI/Psychosis ☐ Suicidal ideation: ☐ Passive ☐ Active ☐ With plan ☐ With intent ☐ Homicidal ideation: ☐ Passive ☐ Active ☐ With plan ☐ With intent ☐ Delusions: _____ ☐ Hallucinations: _____ ☐ **Obsessions:** _____ ☐ **Other:** _____

Cognition: ☐ Alert and oriented (appropriate to age) ☐ Impaired: _____

Insight: ☐ Good ☐ Fair ☐ Poor ☐ Limited by developmental level

Judgment: ☐ Good ☐ Fair ☐ Poor ☐ Limited by developmental level

Risk Assessment

Current Suicidal Ideation: ☐ No ☐ Yes: _____ **Current Homicidal Ideation:** ☐ **No** ☐ **Yes: _____ Self-Harm Behaviors:** ☐ **No** ☐ **Yes: _____ Access to Means:** ☐ No ☐ Yes:

_____ History of Abuse/Trauma: ☐ No ☐ Yes: _____ Bullying (victim or perpetrator): ☐ No ☐ Yes: _____ Protective Factors: _____ Overall Risk Level: ☐ Low ☐ Moderate ☐ High ☐ Imminent

Diagnostic Impression

1. _____
2. _____
3. _____
4.

Treatment Plan

Medications: ☐ Not indicated ☐ Recommended: _____ **Psychotherapy:** ☐ Individual ☐ Family ☐ Group ☐ Other: _____ **Frequency of Follow-up: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other: ____ Labs/Testing Ordered: _____ Referrals: _____ School Recommendations: _____ Safety Plan: ☐ Not indicated ☐ Completed (see attached) Parent/Family Interventions: _____**

Additional Notes

_____

_____

_____

Provider Signature: _____ Date: __ Credentials: _____ License #: _____

_____

Web Implementation Notes

This form should be implemented with: - Age-appropriate sections that appear based on patient age - Separate parent/guardian and patient input sections - Developmental milestone assessment with visual timeline - School information section with academic history - Age-based scoring for assessment tools - Growth chart visualization capability - Parent/guardian electronic signature capability - Mobile-responsive design with larger touch targets - PDF export functionality - Save/load capability - Conditional logic to show relevant sections based on age and presenting concerns