Shanti Wellness, LLC
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Intake Questionnaire

****Please complete this form send it back to the clinic prior to the first appointment****

Client Name: _____ Date of Birth: _____ Age: _____

Assigned Gender at Birth: _____ Preferred Gender Identity: _____

Mother's Name: _____ Occupation: _____

Home Phone # _____ Cell Phone # _____

Father's Name: _____ Occupation: _____

Home Phone # _____ Cell Phone # _____

Other Guardian's Name: _____ Occupation: _____

Home Phone # _____ Cell Phone # _____

Please list all individuals who have legal custody of child (authority to make medical decisions and sign consent forms)? _____

_____

Client's Home Address: Street: _____

City: _____ State: _____ Zip: _____

Guarantor's Name and Address: Name _____

Street: _____

City: _____ State: _____Zip: _____

Child's Strengths/Talents: _____

_____

_____

Child's Interests/Hobbies/Sports: _____

_____

_____

Child's Current School: _____ Grade: _____

School Phone # _____ Academics performance (grades): _____

Please list any Special Education (504, IEP, etc.) and reason for the services. Also include services provided and type of classes (regular, pull-out, etc.): _____

_____

_____

Current Problems and reason for seeking evaluation (use back of page if needed):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Mark below if your child has these issues currently/recently or in the past *(Mark "C" for currently/recently and "P" for in the past):*

___ depressed mood ___ decreased energy ___ sleep changes ___ low self-esteem

___ irritability ___hopelessness ___ appetite changes ___ decreased concentration/grades

___ suicidal thoughts/attempts ___ self-harming thoughts/behaviors ___ aggression/assaults

___ thoughts of hurting others ___ elevated mood ___ racing thoughts ___ rapid speech

___ decreased need for sleep ___ grandiose behavior/thoughts ___ nervousness/worrying

___ separation anxiety ___ school anxiety ___ anxiety in social/public situations ___ fears

___ nightmares ___intrusive traumatic memories ___ flashbacks about trauma

___ obsessions ___ compulsions ___ Motor or vocal tics ___ impulsivity

___ decreased attention/concentration ___ hyperactivity ___ trouble completing tasks

___easily distracted ___ oppositional ___ lying ___ fighting ___ stealing ___ running away

___ destruction of property ___ skipping school ___ school refusal ___ school behavior issues

___ fire-setting ___ cruelty to animals ___ hallucinations ___ disorganized/bizarre behavior

___ disorganized/bizarre speech ___ delusions (believes things are true when they aren't)

___ body image issues ___ self-induced vomiting ___ binge eating ___ excessive exercising

___ excessive weight loss/gain ___ loss of menstrual cycle ___ enuresis ___ encopresis

Past Mental Health History

Current and prior psychiatrists (include dates of treatment and phone #): _____

_____

_____

_____

Current and prior therapy (include therapist's name, dates of treatment, and phone #):

_____

_____

_____

Prior Psychological Testing (dates, name of psychologist, results): _____

_____

Current Psychiatric Medications:

Name of medication	Dose/Frequency	Date Started	Side Effects? Does it help?

Past Psychiatric Medications:

Name of medication	Dose/Frequency	Dates Taken	Reason for Discontinuation

Past suicide attempts or urges/threats (dates, what occurred, outcome): _____

_____

Past self-harming or urges/threats (dates, what occurred, outcome): _____

_____

Past aggression/violence or threats (dates, what occurred, outcome): _____

_____

Hospitalizations for mental health reasons:

Name of Hospital	Reason	Dates

Substance Use History: Please list substances and other details requested below. Include any nicotine use in any form (specify how it's used), alcohol, marijuana, other illegal drugs, prescription medications, or other substances.

Name of substance	Amount and Frequency	Dates Used (if known)	Consequences of Use (legal, academic, relationship issues, etc)

Medical History: Please mark "N/A" or "None" if an item doesn't apply to your child

Primary Care Doctor: Name _____ Phone # _____

Are immunizations up to date? ____ If no, please explain: _____

Date of child's last annual physical exam? _____ Was everything normal? _____

Allergies to Medication and reaction: _____

_____

Allergies to Food and reaction: _____

Any hearing or vision problems (please describe): _____

_____

Any exposure to toxic substances/chemicals such as lead, asbestos, etc. (please describe):

_____

Any history of seizures (please describe type, date of last seizure, treatment received): _____

_____

Serious injuries, including head injuries, concussions, dates of injury, and outcomes: _____

_____

Current and Past Medical Problems and treatment (asthma, other allergies, seizures, thyroid problems, recurrent headaches, fainting, loss of consciousness, diabetes, liver or kidney disease, anemia, etc.):

Medical problem	**Date diagnosed**	**Treatment**

Cardiac/Heart Problems (check all that apply): ___ extreme shortness of breath with exercise

___ decreased exercise tolerance ___ fainting ___ palpitations ___ abnormal heart rhythm

___ murmurs (past or current) ___ other heart problem: _____

Females: Age of first period: ____ Start date of last period: _____ Are cycles regular (Y/N): ____

Child/Adolescent's Sexual Identity (Heterosexual, etc.): _____

Sexual Health (Y/N/Unsure): Sexually active: ___ History of Infection: ___ Uses Protection: ___

Hospitalizations/Surgeries for medical reasons:

Name of Hospital	**Reason**	**Dates**

Current Medications for Medical problems:

Name of medication	**Dose/Frequency**	**Date Started**	**Side Effects? Does it help?**

Developmental History:

Pregnancy term (# of weeks): _____ Child's Birth Weight: _____ Apgar Scores: _____

Was it a high-risk pregnancy? If so, why? _____

Pregnancy Complications (need for medication, medical problems, etc.): _____

_____

Medications were taken during pregnancy: _____

Substances used by mother during pregnancy (including nicotine): _____

Complications during Childbirth: _____

Check the following if applicable: ___ Breech ___ unplanned C-section ___ Jaundice

___ use of forceps or suction ___ required oxygen or ventilator ___ NICU stay ____ Other

Describe child's behavior as infant (colicky, hard to console, sleeping habits, nutrition, too quiet, floppy or limp): _____

_____

Age that child was completely potty trained: Urine _____ Bowel Movements _____

Describe Bedwetting or Bowel accidents: _____

Milestones (after each item, please indicate age when reached):

Roll over _____ Sitting up (w/o support) _____ Crawling _____ Smiling _____ Anxious with strangers _____ First Mama/Dada _____ First words other than Mama/Dada_____ First phrase/sentence _____ First Steps w/o holding something _____ Riding Bicycle _____

Describe any challenges: Sensory issues (noises, textures, foods, etc.): _____

_____

Speech issues (lack of development, delays, repetitive, strange sounds, etc.): _____

_____

Social Issues (peer relationships, eye contact, social cues, etc.): _____

_____

Behavioral Issues (repetitive behaviors or sounds, hand flapping, rocking, head banging, etc.):

_____

Social History:

Child's Place of Birth _____ Whom child lives with: _____

Religious Affiliation (if any) _____ National Heritage _____

Father's Highest Level of Education _____ Employment _____
Religious Affiliation _____ National Heritage _____

Mother's Highest Level of Education _____ Employment _____
Religious Affiliation _____ National Heritage _____

Step-Father's Highest Level of Education _____ Employment _____
Religious Affiliation _____ National Heritage _____

Step-Mother's Highest Level of Education _____ Employment _____
Religious Affiliation _____ National Heritage _____

Please identify marital status including dates of all marriages, divorces, and remarriages for both natural and any step-parents. _____
_____
_____

Please list any significant family or school changes, moves, and major stressors: _____
_____

_____

Please describe child's relationship with parents/guardians, other adults, peers, and friends:

_____

_____
_____
_____

List names of all children including the applicant, step-brothers and sisters, half brothers and sisters.

Name of sibling	Relationship to client	School grade/ Occupation	Lives with client (Y/N)

List any other adults or individuals living in the home:

Name of individual	Relationship to client	Occupation

Trauma: Please indicate whether this child has ever been exposed to abuse or neglect. Please state whether it was physical, sexual, emotional, or some form of neglect. Please describe the outcome and impact.

_____
_____
_____

Family Medical History: Please check each box that applies to the family member.

	Diabetes	Heart Attack age<45yo	Heart Attack age>45yo	Early Death <35yo	Abnormal Heart Rhythm	Other heart problem (specify)	Thyroid Problem	High Cholesterol
Child's Father								
Paternal Grandfather								
Paternal Grandmother								
Father's Siblings								
Child's Mother								
Maternal Grandfather								
Maternal Grandmother								
Mother's Siblings								
Child's Brother(s)								
Child's Sister(s)								
Other (specify)								
Other (specify)								
Other (specify)								
Other (specify)								

Please list any other medical problems (fainting, cancer, etc.) and which family member has them: _____

_____

_____

Family Psychiatric History: Please list family member's relationship, diagnoses, and type of treatment including names of medications, if known. Include diagnoses such as Depression, Anxiety (type, if known), Bipolar disorder, Schizophrenia, Trauma disorder, Eating disorders, Personality Disorders, ADHD, Substance Abuse (drug or alcohol), OCD, Autism Spectrum Disorder, ADHD, and any others that you know of. Continue on back of form if needed.

Relationship to child/client	**Diagnosis**	**Treatment**

Suicides or suicidal thoughts in the family (Y/N): _____ If yes, indicate which family member(s): _____

Self-harming in the family (Y/N): _____ If yes, indicate which family member(s): ____

_____

Violence/aggression/homicidal behavior in the family: _____ If yes, indicate which family member: _____

Incarcerations of any member of the family: _____ If yes, indicate which family member and why: _____

Child's Legal History:

Does child have access to lethal weapons (Y/N): ____

If yes, state type/location in home: _____

Described how weapons are secured: _____

Has the child ever used weapons (Y/N): ____ If yes, describe circumstances: _____

_____

Please describe any involvement with the law or Juvenile Court. Include dates and reasons: _____

_____

Current pending charges or court dates: _____

Court worker/probation officer name: _____ Phone #: _____

Describe any legal or school consequences related to drug or alcohol use: _____

_____

Name of patient (print):_____
Signature of patient: _____ Date: _____

Name of parent/guardian (print):_____
Signature of parent/guardian: _____ Date: _____

Name of clinician (print):_____Sonali Mahajan, MD_____
Signature of clinician: _____ Date: _____