THOMAS M. BROD, M.D.
DISTINGUISHED FELLOW, AMER. PSYCHIATRIC ASSN.
12304 Santa Monica Boulevard, Suite 210
W. Los Angeles, CA 90025
(310) 207-3337

CONFIDENTIAL

Child/Adoloescent Intake Questionnaire

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

PATIENT IDENTIFICATION

Name ______________________________ First Appointment Date ________________________________

Birth Date __________________________ Age _________ Sex _________Employer __________________

Occupation __________________________ Marital Status ____

Address ____________________________ City ______________________ State ____ Zip ______________

E-Mail Address _________________ Home Phone # ___________________ Cell Phone # ________________

Parent's Phone and Contact Information: ____

Who lives with you, currently (names/relationship)? ____

____

____

If father or mother is not in your home, what are the circumstances?____________________________________

____

Referred here by whom:______________________________________ Phone:________________________

Primary Care:____ Phone:________________________

Additional Care:____ Phone:________________________

Insurance Co
Name & Address____

Phone # (______)_____________________ID No. _________________________Group No. ____________________

MAIN PURPOSE OF THE CONSULTATION (Why did you seek the evaluation at this time? What are your goals in being here?) ____

____

Most Prominent Problems **How Long**

1.____

2.____

3.____

4.____

5.____

Name:

How were you before these problems occurred (if relevant)?

____

____

Previous symptoms throughout your entire life:

____

____

Current medications for these problems, reasons for taking them, and their effects on you:

____

____

How much time and money have you spent on your primary problem(s)?

____

____

How will you know you are done?

____

____

MEDICAL HISTORY

Present Height ________ *Present Weight* ________

PRIOR PSYCHOTHERAPY/PSYCHIATRIC HISTORY

(Please include contact with other professionals, medications, types of treatment, etc.)

____

____

____

Current **medical problems/medications**:____

____

Current supplements/vitamins/herbs:____

Past medical problems/medications: ____

____

Other doctors/clinics seen regularly: ____

Any history of head trauma? (describe): ____

____

Ever any seizures or seizure like activity? ____

Prior hospitalizations (place, cause, date, outcome): ___________________________________

Prior abnormal lab tests, X-rays, EEG, etc: ____

Allergies/drug intolerances (describe): ____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

Name:

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)____

School History: Last grade completed ____________ Last school attended ____________________________
Average grades received ______________ Specific learning disabilities ________________________________
Learning strengths ____
Any behavior problems in school? ____
What have teachers said about you?____
Please bring school report cards and any state, national or special testing that has been performed.

Employment History: (summarize jobs you've had, list most favorite and least favorite)
____
Any work-related problems? ____
What would your employers or supervisors say about you? ____

Ever Any Legal Problems? ____

Alcohol and Drug History, if applicable: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

____
Do you or have you ever experience withdrawal symptoms from alcohol or drugs? _______________________
Has anyone told you they thought you had a problem with drugs or alcohol? ___________________________
Have you ever felt guilty about your drug or alcohol use? ____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? __________________
Have you ever used drugs or alcohol first thing in the morning?_______________________________________
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) ______________________________________
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) ____

Sexual history: (answer only as much as you feel comfortable)
Number of sexual partners: 0___ 1-4___ 4-15___ 15+___ If this is an issue for you please indicate: ________
Any history of sexually transmitted disease? _________ History of abortion? ____________________________
History of sexual abuse, molestation or rape? ____
Current sexual problems?____

Name:

Any history of being *physically* abused: ____

____

Cultural/ethnic background ____

____

Describe yourself/your strengths in a few words:-

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

____

____

____

Significant Developmental Events (include birth difficulties, accidents, head injuries, seizures, parents', separations, divorces, re-marriages, deaths, other traumatic events, losses, abuse, etc.)____

____

____

____

Natural <u>Mother's History</u>: age_____ occupation ____

School: highest grade completed ______________

Learning problems ____

Behavior problems ____

Marriages ____

Medical Problems ____

Childhood atmosphere (family position, abuse, illnesses, etc)________________________________

____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _________________

____

Mother's alcohol/drug use history ____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

____

____

Natural <u>Father's History</u>: age_____ occupation ____

School: highest grade completed _____________

Learning problems ____

Behavior problems ____

Marriages ____

Medical Problems ____

Childhood atmosphere (family position, abuse, illnesses, etc)________________________________

____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _________________

____

Father's alcohol/drug use history ____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)

____

____

Siblings (names, ages, problems, strengths, relationship to patient) ________________________________

____

Name:

Quick Assessment (QA, JD Elder)

Name of Patient: ___________________________ **Name of Rater** (**if not self**): ___________________ **Date:** ____________

Please rate yourself, or the person you are assessing, for each of symptoms below. Check only one box on the rating scale for each symptom. If you don't know how to rate a symptom leave it blank.

Rating Scale (Frequency of Symptoms)

Low Frequency Rating: 0 = None -- has not occurred during the last month.
1 = Monthly -- has occurred one or more times during the last month, but not within the last week.

High Frequency Rating: 2 = Weekly -- has occurred one or more times during the last week, but not daily.
3 = Daily -- has occurred daily for the last seven days.

Symptoms	None 0	Monthly 1	Weekly 2	Daily 3	Symptoms	None 0	Monthly 1	Weekly 2	Daily 3
Anxious, fearful, uneasiness, worry, concern					**Racing Thoughts,** many thoughts				
Inattention, daydreaming, hard to stay on task					**Agitation,** upset, disturbed				
Sad and Blue, guilt, helpless, hopeless feelings					**Hyperactive,** excessive movement				
Dull, slow to learn, not sharp					**Difficulty Falling Asleep,** insomnia				
Forgetful, failure to recall or remember					**Impulsive,** spontaneous urge				
Spaciness, fogginess, not tuned in					**Physical Tension in Body,** taut, nervous, tense				
Disrupted Sleep, wakes often, difficulty waking					**Pressure in Chest,** discomfort, pain in chest				
Cries Easily, sheds tears, weeps easily					**Aggressive,** hostile, overly assertive, bold				
Feelings Easily Hurt, vulnerable					**Teeth Grinding**, jaw clenching, tight jaw				
Low Self-esteem, poor self-confidence					**Headaches,** feeling discomfort, unusual feeling				
Lack of Motivation, discouraged					**Crawling Sensations on Skin,** leg twitches				
Confused Thinking, mixed up, baffled					**Sensitivity to Touch,** hands, feet, face				
Nausea, sickness, upset stomach					**Pain Awareness,** long unpleasant sensation				
Loss of Emotional Control, rage, wrath					**Hyper Focused,** overly attentive, very focused				
Lethargic, lazy, drowsy, sluggish, fatigue					**Sad and Angry**, agitated and feeling blue				

Left Subtotals **Right Subtotals**

Grand Total **Left Total** **Right Total**

Questions	Yes	No	Comments
Have you changed medication?			
Have you changed herbs, minerals, supplements, or vitamins?			
Have you had any changes at home?			
Have you had any changes at school?			
Have you had any changes at work?			
Have you had any changes in your personal relationships?			

If you answered yes to any question above, please explain:

List other changes that you have noticed:

Name:

MOOD INVENTORY (BECK)

Please complete if you are 14 or older

These sentences are listed together in groups. After you have read one group of sentences, **pick out ONE in the group** that describes the best pick that describes how you feel. Think about the way you have been feeling **this past week.**

After you pick your answer from the first group of sentences, go on the next group of sentences. there is no such thing as a right answer or a wrong answer. Just pick the answer that describes you best.

PLEASE CIRCLE THE NUMBER NEXT TO THE SENTENCE THAT IS YOUR ANSWER.

1) 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all of the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2) 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3) 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4) 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5) 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel guilty most of the time.
   3 I feel guilty all of the time.

6) 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished

7) 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8) 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9) 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself.
   2 I would like to kill myself.

Name:

3 I would kill myself if I had the chance.

10) 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11) 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

12) 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13) 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14) 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15) 0 I can work about as well before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16) 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and I find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17) 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing anything.
3 I am too tired to do anything.

18) 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19) 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes____ No____

Name:

20) 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems, that I cannot think about anything else.

21) 0 I have not noticed any recent changes in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Fees and Cancellation Arrangements

I understand that fees are due at the time of service unless other arrangements have been made with Dr. Brod.

I am responsible for fees for all scheduled sessions. I understand that cancellations do not cancel my agreement to pay. THERE IS NO "24-HOUR" CANCELLATION UNDERSTANDING. However, if my vacant time can be filled by another patient, I am no longer obligated to pay for missed time.

SIGNED: (Patient, or Parent, if Minor) ______________________________ DATE ____________