
Questions Frequently Asked about Intake Evaluations

Please read this prior to completing your intake packet.

What is an intake evaluation?

An intake evaluation is a bio-psycho-social interview, which is a symptom and behavior focused interview.

Who conducts the intake evaluation?

Intake evaluations are conducted by a Psychology intern or extern, or a Licensed Clinical Social Worker.

How long does an intake evaluation last?

The appointment is typically 60-90 minutes in length.

What is the purpose of an intake?

An intake evaluation is used as a tool for the clinician to further assess what types of services are indicated to treat the symptoms that your child is experiencing.

What happens after the intake?

During this appointment, it will be determined if further evaluation is indicated, and/or what type of treatment can be provided by The Children's Hospital, and/or whether there is a more appropriate setting in the community to provide services. After the completion of the intake evaluation, the clinician who evaluated your child discusses the needs, and possibilities for treatments in an Intake Disposition Rounds meeting which consists of faculty psychiatrists, psychologists, social workers, and other clinicians.

How will I know what is decided in the Intake Disposition Rounds?

You will be contacted by the clinician who conducted the intake to discuss the recommendations for treatment. If you have not heard from the clinician who conducted the intake, another provider in our outpatient clinic, or a scheduler, feel free to contact the clinician who conducted the intake. The main phone number for the Department of Psychiatry and Behavioral Health Outpatient Clinic is 720-777-6200.

Why is it important to complete the intake packet prior to the intake evaluation taking place?

The information that you provide in the intake packet allows the clinician who is evaluating your child to spend more time focusing on the symptoms and behaviors that are most concerning, in addition, it provides the treatment team with more information to keep intake evaluations brief. Due to the importance of the intake packet, you must complete the questionnaire prior to us scheduling your first appointment.

If I am seeing more than one clinician in the outpatient clinic (example: a psychology intern and a psychiatrist) do I need to complete the packet more than once?

No, it is not necessary to do so because after you complete the intake packet and the clinician who it is given to is through with it, it is then scanned into your child's medical record so that other providers may utilize it.

The Children's Hospital Psychiatry and Behavioral Sciences

Dear Parents:

Completing this form now will help us reduce the time and cost of gathering this information at our office.

Parents who are divorced, or are divorcing and share custody, please note that we will need one of the following:

- Signed consent to treat from both parents
- A copy of the custody agreement designating parental decision making right
- Or both parents to participate in the intake

If you have any testing results for your child (educational or psychological,) please bring those with you to your first appointment as well.

We appreciate your cooperation and patience.

Child's Name: _____ **Birth date:** _____ **Today's Date:** _____

Please describe the concerns you have that led to this referral. Examples: Concerning behaviors or disturbances in mood, sleep, appetite, anxiety or concerns about school performance, family or peer relations

Child's Current or Past Therapists or Counselors (if any):

Name	Address	Phone Number

Do we have your permission to contact the above therapists? _____

If yes, signature: _____ Date: _____



Please comment on how your child has been performing in school, socially, academically and behaviorally, during the past month:

Please fill in for all previous school years:

Grade	School Name	Academic Performance			Behavior		
		Good	Fair	Poor	Good	Fair	Poor
Preschool							
Kindergarten							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							



Grades repeated: _____ Grades skipped: _____ Expelled? YES NO How many times? _____

Does your child have any known learning disabilities? YES NO

Is your child receiving any special education services (speech, reading, etc)? YES NO

Explain: _____

May we have your permission to contact the child's teacher/school? YES NO

If yes, signature: _____ Date: _____

Medical History

Birth History Mother's age at time of birth: _____ years

Father's age at time of birth: _____ years

Was this a planned pregnancy? YES NO

Did Mother smoke during pregnancy? YES NO Drink Alcohol? YES NO

Was Mother under a doctor's care during pregnancy? YES NO

Please list any difficulties you may have experienced during pregnancy, labor or delivery:



Development

As closely as you can remember about your child:

Age of sitting alone_____ Age of rolling over_____ Age of walking_____

Large motor skills developed: Fast Slow Average

Did your child seem more clumsy than other children? YES NO

Did your child point to things? YES NO

Age of first words_____ Age of talking in sentences_____

Speech developed: Fast Slow Average

Is your child: Right-handed Left-handed Uses both hands equally

Age when child chose one hand more than the other_____

Age when child stayed dry during day_____

Age when child stayed dry during night_____

Age when child was bowel trained_____

Temperament

As an Infant/Toddler did your child establish the following routines normally?

Sleep/wake Cycle? YES NO Eating? YES NO

Did your child have colic? YES NO

Was your child interested in other people? YES NO

Was your child sensitive to:

Particular sounds (sirens, loud noises)? YES NO

Particular sensations (tags on clothes, socks, light touch, movement such as swinging)? YES NO

Particular smells? YES NO Particular tastes? YES NO

Was your child: Slow to warm up? YES NO Shy? YES NO

Underactive? YES NO Overactive? YES NO Aggressive? YES NO



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Current Sleep Routines	At least 5 nights/wk	1 - 5 nights/week	Less than 3 times/month
How often does your child sleep in his own bed?			
How often does your child sleep in parents' bed?			
How often does your child sleep somewhere else?			
How often does your child fall asleep within 20 minutes by themselves?			
How often does your child fall asleep within 20 minutes with parents' help?			
How often does your child wake during the night?			

Medical History of Child: Has your child had any of the following? Check any that apply.

Measles	
Whooping Cough	
Meningitis	
Chicken Pox	
Strep Throat	
German Measles	
Diphtheria	
Encephalitis	
Mumps	
Flu	
High Fever	

Ear Infections	
Tubes in Ears	
Problems with Hearing	
Problems with Vision	
Allergies	
Asthma	
Convulsions (Seizures)	
Head Injuries	
Other Injuries	
Other Illnesses	
Other	

Does your child have allergies to medications? YES NO If yes, please list:



Has your child ever been hospitalized? YES NO If yes, please explain:

Does your child take prescribed medications (psychiatric or medical) now? YES NO
 If yes, please list:

Has your child taken psychiatric or medical medications in the past? YES NO
 If yes, please list:

Does your child take any over the counter medications? YES NO If yes, please list:

Does your child take any herbal or homeopathic remedies? YES NO If yes, please list:

Have you ever been told that your child has or has had a heart problem of any type other than an innocent murmur?
 YES NO

Has your child ever been dizzy or passed out with exercise? YES NO

Has your child ever had an irregular or abnormally rapid heart beat? YES NO

Has anyone in your family, back to grandparents, died of heart problems or died suddenly prior to age 50 years? YES NO

Do any family members have high blood pressure or cholesterol problems? YES NO

Family Medical History: Please check the illnesses that any of your child's BIOLOGICAL relatives have experienced:

ILLNESS	Mother	Father	Sister or Brother	Aunt or Uncle	Grand parent	Cousin
ADHD (hyperactivity)						
Allergies						
Alcohol or Drug Abuse						
Anxiety						
Asthma						



ILLNESS	Mother	Father	Sister or Brother	Aunt or Uncle	Grand parent	Cousin
Bipolar Disorder						
Cancer						
COPD (emphysema)						
Depression						
Diabetes						
Epilepsy (Seizures)						
Learning Problems						
Legal Problems						
Mania						
Obsessive-Compulsive Disorder (OCD)						
Panic Disorder)						
Rheumatic Fever or						
Heart Disease						
Schizophrenia						
Thyroid Problem						
Tics						
Vocal cord dysfunction						
Other						

Is there anything else you want us to know about your child's or your family's medical history?



Please complete the following behavioral and symptom checklist

		Not At All	Sometimes	Frequently
1	Fails to give close attention to details or makes careless mistakes			
2	Has difficulty paying attention to tasks or play activities			
3	Does not seem to listen when spoken to directly			
4	Has difficulty following through on instructions and fails to finish things			
5	Has difficulty organizing tasks and activities			
6	Avoids doing tasks that require a lot of mental effort (schoolwork, homework, etc.)			
7	Loses things necessary for activities			
8	Is easily distracted by other things going on			
9	Is forgetful in daily activities			
10	Fidgets with hands or feet or squirms in seat			
11	Has difficulty remaining seated when asked to do so			
12	Runs about or climbs on things when asked not to do so			
13	Has difficulty playing quietly			
14	Is "on the go" or acts as if "driven by a motor"			
15	Talks excessively			
16	Blurts out answers to questions before they have been completed			
17	Has difficulty awaiting turn in group activities			
18	Interrupts people or butts into other children's activities			
19	Loses temper			
20	Argues with adults			
21	Defies or refuses what you tell him/her to do			
22	Does things to deliberately annoy others			
23	Blames others for own misbehavior or mistakes			
24	Is touchy or easily annoyed by others			



		Not At All	Sometimes	Frequently
25	Is angry and resentful			
26	Takes anger out on others or tries to get even			
27	Plays hooky from school			
28	Stays out at night when not supposed			
29	Lies to get things or to avoid responsibility ("cons" others)			
30	Bullies, threatens, or intimidates others			
31	Starts physical fights			
32	Has run away from home overnight			
33	Has stolen things when others were not looking			
34	Has deliberately destroyed others' property			
35	Has deliberately started fires			
36	Has stolen things from others using physical force			
37	Has broken into someone else's house, building, or car			
38	Has used a weapon when fighting (bat, brick, bottle, etc)			
39	Has been physically cruel to animals			
40	Has been physically cruel to people			
41	Has been preoccupied with or involved in sexual activity			
42	Is overly concerned about abilities in academic, athletic, or social activities			
43	Has difficulty controlling worries			
44	Acts restless or edgy			
45	Is irritable for most of the day			
46	Is extremely tense or unable to relax			
47	Has difficulty falling asleep or staying asleep			
48	Complains about physical problems (headaches, upset stomach, etc) for which there is no apparent cause			
49	Shows excessive fear to specific objects or situations (animals, heights, storms, insects, etc)			
50	Cannot get distressing thoughts out of his/her mind (worries about germs or doing things perfectly, etc)			
51	Feels compelled to perform unusual habits (hand washing, checking locks, repeating things a set number of times)			
52	Has experienced an extremely upsetting event and continues to be bothered by it			
53	Does unusual movements for no apparent reason (eye blinking, twitching, lip licking, head jerking, etc)			
54	Makes vocal sounds for no apparent reason (coughing, throat clearing, sniffing, grunting, etc)			



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		Not At All	Sometimes	Frequently
55	Has strange ideas or beliefs that are not real (child's food is poisoned, people are trying to get him/her, etc)			
56	Has auditory hallucinations - hears voices talking to or telling him/her to do things			
57	Has extremely strange and illogical thoughts or ideas			
58	Laughs or cries at inappropriate times or shows no emotion in situations where most others of same age would react			
59	Does extremely odd things (excessive preoccupation with fantasy friends, talks to self in a strange way, etc)			
60	Is depressed for most of the day			
61	Shows little interest in (or enjoyment of) pleasurable activities			
62	Has recurrent thoughts of death or suicide			
63	Feels worthless or guilty			
64	Has low energy level or is tired for no apparent reason			
65	Has little confidence or is very self conscious			
66	Feels that things never work out right			
67	Has experienced a big change in his/her normal appetite or weight (circle YES or NO)	NO	YES	
68	Has experienced a big change in normal sleeping habits - cannot sleep or sleeps too much (circle YES or NO)	NO	YES	
69	Has experienced a big change in normal activity level - overactive or inactive (circle YES or NO)	NO	YES	
70	Has experienced a big change in his/her ability to concentrate (circle YES or NO)	NO	YES	
71	Has experienced a big drop in school grades or schoolwork (circle YES or NO)	NO	YES	
72	Has a peculiar way of relating to others (avoids eye contact, odd facial expressions or gestures, etc)			
73	Does not play or relate well with other children			
74	Not interested in making friends			



		Not At All	Sometimes	Frequently
75	Is unaware or takes no interest in other people's feelings			
76	Has a significant problem with language			
77	Has difficulty making socially appropriate conversation			
78	Talks in a strange way (repeats what others say; confuses words like "you" and "I"; uses odd words or phrases, etc)			
79	Is unable to "pretend" or "make believe" when playing			
80	Shows excessive preoccupation with one topic			
81	Gets very upset over small changes in routine or surroundings			
82	Makes strange repetitive movements (flapping arms, etc)			
83	Has strange fascination for parts of objects			
84	Tries to avoid contact with strangers; abnormally shy			
85	Is excessively shy with peers			
86	Is generally warm and outgoing with family members and familiar adults			
87	When put in an uncomfortable social situation, child cries, freezes, or withdraws from interacting			
88	Gets very upset when child expects to be separated from home or parents			
89	Worries that parents will be hurt or leave home and not come back			
90	Worries that some disaster (getting lost, kidnapped, etc) will separate child from parents			
91	Tries to avoid going to school in order to stay home with parent			
92	Worries about being left at home alone or with a sitter			
93	Afraid to go to sleep unless near parent			
94	Has nightmares about being separated from parent			
95	Complains about feeling sick when child expects to be separated from home or parents			
96	Wets bed at night			
97	Wets or soils underwear during daytime hours			
98	Does your child have periods when his mood is abnormally happy, giddy, expansive or like he is "punch drunk?"			



		Not At All	Sometimes	Frequently
99	Does your child have periods when his mood is abnormally irritable, angry, explosive or belligerent?			
100	Does your child have periods of grandiose or wild ideas or an exaggerated sense of his abilities?			
101	Does your child have periods when he doesn't seem to need sleep?			
102	Does your child have periods when he talks much more or faster than usual?			
103	Does your child have periods when his thoughts are racing or confusing?			
104	Does your child have periods when he is more distractible than usual?			
105	Does your child have periods when he is more physically active and driven than usual or compulsively involved in multiple, lengthy or repetitive activities?			
106	Does your child have periods when excessively drawn toward daredevil, high-risk or dangerous behavior?			
107	Have you ever been concerned that your child's behavior was inappropriately physical, affectionate, intrusive or precociously sexual?			

