Iowa Specialty Hospitals & Clinics

CHILDREN- Behavioral Health Services Patient Form

PATIENT INFORMATION **Today's date: ____/____/____**

Child Last name:	**MI:**	**Child First Name:**
Parent Name:	**Phone:**	**Date of Birth:**
Parent Name:	**Phone:**	**Parents Marital Status:**
Who has legal custody:	**Visitation schedule:**	**Insurance:**

Address:	**Home Phone:**
Address (PO Box, Apt #):	**Cell Phone:**
City:	**County:**
State/Zip:	**Email:**
Gender: **Pronouns:** He/Him/His She/Her/Hers They/Their/Theirs	**Ethnicity:** ☐ Not Spanish, Hispanic, Latino or Mexican ☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic or Latino ☐ Unknown
Race: ☐ Caucasian ☐ Black/African American ☐ American Indian ☐ Asian ☐ Alaskan Native ☐ Hawaiian or Pacific Islander ☐ Unknown	**Reason for Seeking Assessment (Circle all that apply):** Mental Health Substance Abuse

Referral Source (circle all that apply): Court Ordered *State Probation/Parole *Federal Probation/Parole *DHS Employer Hospital Self-Referral OWI/Zero Tolerance Other:_____
*DHS Worker Name:_____ *PO Worker Name: _____

Communication Method: Communication Device Sign Language Verbal
Spoken & Written Language: English Spanish Other:_____

Emergency Contact

Last name:	**MI:**	**First Name:**
Address:	**Phone:**	
City/ State/Zip:	**Relationship to patient:**	

Complaint

Primary reason you are concerned about your child? -

_____ _____

Start Date: _____Have they previously suffered from this complaint? _____

Iowa Specialty Hospitals & Clinics

Current Symptoms		
Child Behaviors	**Past Concern**	**Present Concern**
Trouble Hearing		
Overly Sensitive to Sounds		
Visual Problems		
Tilts Head to look at items		
Daytime toileting accidents		
Poor eye contact		
Does not play with other children		
Difficulty with change in routine		
Very sensitive to textures		
Stares into space, seen in a trance		
Easily frustrated		
Easily annoyed/annoys others		
Frequent tantrums		
Irritable/short tempered		
Rarely smiles, laughs		
Eats non-food items		
Headaches/stomachaches		
Aggressive towards others		
Cruel towards others		
Hurting others/ fighting		
Hurting others sexually		
Destructive behavior		
Runs away from home		
Shoplifting, stealing		
Trouble with the law		
Fire setting		
Frequent lying		
Swearing		
Rapid, Intense mood swings		
Frequent outbursts		
Significant weight change		
Appetite Fluctuations		
Declining school grades		
Refusal to attend school		
Problems completing school work		
Trouble following rules		
Bullied/picked on by peers		
Paranoid thoughts		
Suicidal thoughts/attempts		

Homicidal thoughts		
Hallucinations		
Morbid thoughts		
Reoccurring motor movements		
Reoccurring vocalizations		
Loss of interest in prior activities, hobbies		
Problematic electronic devices		
Sleep Problems		
Nightmares		
Fatigue/ low energy		
Concentration/attention problems		
Easily Distracted		
Forgetful/ Memory Problems		
Trouble Sitting Still		
Talks excessively/interrupts		
Impulsive		
Depression		
Anxiety/panic attacks		
Excessive worry/ fearfulness		
Social fears/ shyness		
Separation anxiety		
Cries easily		
Perfectionism		
Blames others for problems		
Argumentative/defiant		

Additional Comments:

_____

_____

Infant Sensitivity-

Between the ages of 0-2 years old, was the child extremely sensitive to:

	Yes	**No**
Slight changes in touch		
Slight changes in sound level		
Slight changes in lighting		

Infant Behaviors-

Between the ages of 0-2 years old, was your child

	Yes	**No**
Unable to develop regular sleep pattern		
Very difficult to soothe when upset		
Unable to calm self when distressed		

Unable to separate from parent without distress		
Unable to show affection		

Developmental Milestones-

	Early	On Time	Late	Don't know
Walked alone				
Said first words				
Daytime toileting				
Bladder training				
Bowel training				
Tied shoelace				
Wrote name				

Additional Comments:

_____

_____

Medical

Vision problems? ☐ Yes ☐ No Hearing problems? ☐ Yes ☐ No Dental problems? ☐ Yes ☐ No

Any previous loss of consciousness or head injuries: _____

Medical problems your child has: _____

Previous surgeries: _____

How would you rate your child's overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are your child's immunizations current if under the age of 16? __No __Yes

Providers

Name of Primary Care Physician:	Practice Facility Name and City:
Primary Care Physician:	
Name of Dentist:	
Name/Specialty of Specialist:	
Name/Specialty of Specialist:	
Name of therapist:	

Current Medications:

Medication Name	Dose and Frequency	Reason	How long & Effectiveness

Allergies: _____

Iowa Specialty Hospitals & Clinics

Infectious Disease (Diagnosed or Suspected) and STD Risk

Disease or Exposure	No or N/A	Past	Current	Receiving/ ed treatment
Hepatitis Type				
HIV or AIDS (optional)				
IV drug use				
Tuberculosis (TB)				
TB Exposure				
Sexually Transmitted Disease (STD)				
Sexual Contact without barrier protection				
Blood transfusion				
Yellow jaundice				
Share needles/work				
Exchange sex for money or drugs				
Been involved in a sexual assault				

Hospitalizations (psychiatric & medical):

Date:	Reasons:

Substance Use History

Substance of Use	Age of First use & Last date of use	Pattern of Use within last 6 months	Method of Use

Family History of Substance use:

_____

_____

Substance Use- Caregiver Reported Concerns:

	Yes	No
Consumed Alcohol, used drugs		

Been caught in possession of alcohol, drugs, paraphernalia		
Become friends with users of alcohol, drugs		
Misused or taken more than prescribed meds		
Taken meds prescribed for someone else		
Received substance use counseling		

Additional Comments:

_____

_____

_____

Tobacco use

Do they use tobacco? ☐ No ☐ Yes

Would they like assistance to quit? ☐ No ☐ Yes

Birth & Social History

Mother used during pregnancy: ☐ Alcohol ☐ Drugs ☐ Cigarettes

Delivery: ☐ Normal ☐ Breech ☐ Cesarean ☐ Full term ☐ premature ☐ number of week's _____

Birth Weight: _____ Problems at birth:_____

Birth place: _____ Does your child have siblings? _____

Were there any complications during pregnancy? __No __Yes

If yes please explain? _____

_____

Sibling's names and their ages: _____

_____

Is there anyone else who lives in the home? _____

How old when adopted? _____

Parent's occupation: _____

Parent's occupation: _____

How is your child disciplined? _____

Are you as a parent experiencing issues with marriage or parenting? _____

Has your child ever been in out of home placement (residential, PMIC, with family members, group care, etc)? If yes, when and where? _____

_____

List any history of illness (mental or other) among blood relatives:

_____

In the first two years, did your child experience: Separation from mother ☐ Out of home care ☐ Abuse ☐

Disruption in bonding ☐ Depression of mother ☐ Neglect ☐ Chronic pain ☐ chronic illness ☐ Parental Stress ☐

Iowa Specialty Hospitals & Clinics

Trauma & Abuse History

Exposure (experienced or witnessed)	No or Not applicable	Past	Current	Receiving/ ed treatment
Experience or witness physical abuse				
Experience or witness emotional abuse				
Experienced or witness sexual abuse				
Experience or witness domestic abuse				
Traumatic experiences (could include childhood experiences, loss, car accident, violence, war, sexual assault, neglect, natural disaster or anything that was overwhelming to you)				

School History

Where does your child attend school? _____

Grade Level: _____Typical grades: _____

What are your child's academic strengths? _____

What areas are you concerned about?_____

Have you noticed a change in your child's performance at school? _____

_____

What activity does your child participate in/enjoy doing?

_____

Any previous testing (school/psychological)? If yes, when and by whom?_____

_____

Education Details:

	Yes	No
Attends school Regularly		
Grade repeated		
Suspensions, expulsions		
Special Education Services (IEP)		
504 Plan		
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Honors program		
Resource		

Additional Comments:

_____

_____

Iowa Specialty Hospitals & Clinics

School Performance:

	Excellent	Above Average	Average	Somewhat of a problem	Problematic
Reading					
Writing					
Mathematics					
Organizational Skills					
Assignment Completion					
Relationship with Peers					
Relationship with teacher					

Additional Comments:

_____

_____

Military Family and Deployment

Anyone in your family currently serving on active duty in the Armed Forces, the Reserves, or the National Guard?

☐ No ☐ Yes ☐ Prefer not to answer

If "yes" in which of the following have you ever served? Please answer for each of the following. You may say yes to more than one.

Branch of service	Yes	No	Prefer not to answer
Armed Forces	☐	☐	☐
Reserves	☐	☐	☐
National Guard	☐	☐	☐

Employment

Employer	Estimated hire date	Estimated End date	Job duties/ Reason for leaving/ Comments

Legal

In the past 30 days, how many times have you been arrested	○ _____ times ○ Don't want to answer ○ Don't know

Is this assessment court ordered? Do you have a pending court date?	☐ No ☐ Yes- If yes, what county? ☐ No ☐ Yes- If yes, when is your court date?
Is this assessment for OWI or Zero Tolerance Offense? BAL? _____ If yes, was an accident involved?	☐ No ☐ Yes ☐ No ☐ Yes
Are you on probation? Are you involved with Department of Human Services?	☐ No ☐ Yes ☐ No ☐ Yes

Strengths and Goals

What are your child's strengths? _____

What are your goals for treatment? _____

What would your child like to change/work on? _____

What would you like to see happen as a result of this evaluation?

_____

_____

Is there anything else that is important for us to know?

_____

_____