

Thank you for choosing Pine Rest Christian Mental Health Services. We look forward to providing services to your child.

**In order to make the most of your first appointment, please come at least 20 minutes prior to your scheduled time. It is important that you bring the following items with you:**

**1) Completed paperwork**

In order for us to provide the highest quality service, it is important for us to obtain a detailed personal and family history. Also, information about medical conditions and current medications can be very important, so please include this information on the forms to the best of your ability. **If you have a typed list of your current medications, you may bring that in rather than fill out the current medication form.**

**2) Your Insurance Card(s)**

We will be scanning your card(s) into our system. Please contact your insurance company to verify your outpatient behavioral health benefits and secure any preauthorization requirements. If a required authorization is not obtained, you will be responsible for payment of services

**3) A picture I.D.**

We will be scanning your driver's license or picture I.D. into our system for verification of your identity and to protect you from medical identity theft.

**4) Copayment and/or Deductible (amount not covered by insurance)**

Insurance co-payments and deductibles are payable at the time of service. Most insurance companies do not cover 100% of charges.

**5) Proof of Guardianship**

**In case of a minor or an adult under guardianship, a parent or legal guardian must be present at the first appointment.** If you are not a biological parent, you must bring in proof of guardianship.

**Please do not bring other children with you to this appointment. Children cannot be left unattended.**

As a reminder, in order to avoid being charged, please give at least 24-hour notification for broken or canceled appointments. If you have any questions, please call our information office at (616) 831-2601 or 1 (866) 457-6363. Thank you.

**OUTPATIENT INITIAL ASSESSMENT/TREATMENT PLAN  
CHILD/ADOLESCENT PART I**

**INSTRUCTIONS:** To assist us in understanding and helping your child, please fill out this form as completely as possible. This information is confidential and only released with your permission.

**IDENTIFICATION:**

Patient's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Ethnic background:  American Indian/Alaska Native  Asian  Black/African American  
 Caucasian/White  Hispanic/Latino  Other \_\_\_\_\_

Person Completing Form \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**PRESENTING PROBLEM:**

What is your/your child's reason for seeking treatment? \_\_\_\_\_

Who referred you/your child to this Pine Rest location? \_\_\_\_\_

What are your expectations for treatment? \_\_\_\_\_

How involved would you like to be in your child's treatment? \_\_\_\_\_

**MEDICAL HISTORY:**

Has your child ever had/currently have:

Any past surgical procedures?  No  Yes If yes, list: \_\_\_\_\_

Any exposure to contagious diseases such as Tuberculosis?  No  Yes If yes, exposed to what and when did the exposure take place? \_\_\_\_\_

Are immunizations current?  No  Yes

Any functional impairments?  No  Yes If yes, what type of impairment and have there been any rehab services for this? \_\_\_\_\_

Any current pain?  No  Yes If yes, type and duration: \_\_\_\_\_

Pain severity (if applicable)? (rate 1 to 10 with 1 being the least amount): \_\_\_\_\_

Any past issues with pain?  No  Yes If yes, when? \_\_\_\_\_

Any substantial weight loss or gain in one month?  No  Yes When and how much? \_\_\_\_\_

Any special diet being followed or desire for information about special diets?  No  Yes

## SUBSTANCE USE HISTORY:

Please list any inpatient or outpatient treatment or educational programs for alcohol or drug use your child has received:

WHERE, WITH WHOM & WHY	TYPE OF TREATMENT	DATES	WAS IT HELPFUL?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If your child uses drugs or alcohol, what is the current substance of preference? \_\_\_\_\_

Please list any incidents of overdoses, withdrawal or other adverse reaction(s) to drugs or alcohol, date(s) and description:

\_\_\_\_\_

\_\_\_\_\_

Check any word(s) that best describes your child's alcohol or drug use:

- |                                       |                                       |                                    |                                  |
|---------------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> EXPERIMENTAL | <input type="checkbox"/> RECREATIONAL | <input type="checkbox"/> ABUSIVE   | <input type="checkbox"/> NONE    |
| <input type="checkbox"/> ADDICTIVE    | <input type="checkbox"/> DEPENDENT    | <input type="checkbox"/> ALCOHOLIC | <input type="checkbox"/> MINIMAL |

## BIRTH AND DEVELOPMENT HISTORY:

Please complete as much of the following about your child as possible:

Is this child adopted?  No  Yes If yes, at what age? \_\_\_\_\_

### PREGNANCY:

Number of pregnancies of mother: \_\_\_\_\_ Which pregnancy number was this child? \_\_\_\_\_

During pregnancy, did this child's mother:

- |                                                                                                              |                                                                                                                |
|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Have high blood pressure? <input type="checkbox"/> No <input type="checkbox"/> Yes                           | Have recurrent emotional problems? <input type="checkbox"/> No <input type="checkbox"/> Yes                    |
| Have diabetes or sugar in urine? <input type="checkbox"/> No <input type="checkbox"/> Yes                    | Have kidney problems or protein in urine? <input type="checkbox"/> No <input type="checkbox"/> Yes             |
| Take any medications? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>If yes, which? _____       | Experience bleeding? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>If yes, when? _____           |
| Have German Measles? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>If yes, when? _____         | Frequently smoke cigarettes? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>About how much? _____ |
| Drink alcoholic beverages? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>About how much? _____ | Have a drug dependency? <input type="checkbox"/> No <input type="checkbox"/> Yes                               |
| Have hormone pills or injections? <input type="checkbox"/> No <input type="checkbox"/> Yes                   | Other: _____                                                                                                   |

**BIRTH:** Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_ Length of pregnancy: \_\_\_\_\_

Was delivery:  Difficult  Easy  Slow  Quick

Were there any complications for delivery, i.e. Caesarean section or breech birth?  No  Yes

If yes, please explain: \_\_\_\_\_

Was there anything wrong with this baby at birth?  No  Yes

If yes, please explain (e.g. needed to be revived, have yellow jaundice, need oxygen): \_\_\_\_\_

**FEEDING:** Was this baby  Breast fed  Bottle fed Age weaned: \_\_\_\_\_

**DEVELOPMENT:** Was your child's development in the following areas early, normal or delayed?

	AGE IF KNOWN	EARLY	NORMAL	DELAYED
Sit alone				
Roll over				
Stand alone				
Walk by self				
Dress self (except for buttons and tying knots)				
Feed self with spoon or fork				
Speak first words (other than Mama/Dada)				
Speak first real sentences				
Become bladder trained (infrequent daytime accidents)				
Become nighttime trained (rare accidents)				
Become bowel trained (no accidents)				
Help with household tasks				
Ride a tricycle				
Ride a bike				
Tie own shoes				

**SOCIAL/CULTURAL/SPIRITUAL INFORMATION:**

What is your child's present religious affiliation? \_\_\_\_\_

Does your child have any spiritual concerns that should be addressed in the therapy process?  No  Not sure  Yes,

Describe \_\_\_\_\_

What ethnic group does your child identify with? \_\_\_\_\_ To what extent? \_\_\_\_\_

Who does your child count on in times of trouble? \_\_\_\_\_

**EDUCATION INFORMATION:**

What is the highest level of school your child has completed? \_\_\_\_\_

Most recent school attended (attending): \_\_\_\_\_

Has your child experienced any of the following in school?  Learning Problems  Discipline Problems  
 Social Problems  Emotional Problems

Has there been any academic or psychological testing done at school or elsewhere?  No  Yes

If yes, when? \_\_\_\_\_

Results: \_\_\_\_\_

What have been your child's usual report card grades? \_\_\_\_\_

What have been your child's most recent grades? \_\_\_\_\_

**DAILY ACTIVITY INFORMATION:**

List a few of your child's typical week day routines & activities: \_\_\_\_\_

List a few of your child's typical weekend routines & activities: \_\_\_\_\_

**LEGAL HISTORY:**

Please list any contacts your child has had with the courts: \_\_\_\_\_

Please list any contacts your child has had with the police: \_\_\_\_\_

**EMPLOYMENT HISTORY:**

Please list any employment or regular chores of your child: \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:**

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Deceased?  No  Yes If yes, when? \_\_\_\_\_

Description of relationship between father and child: \_\_\_\_\_

\_\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Deceased?  No  Yes If yes, when? \_\_\_\_\_

Description of relationship between mother and child: \_\_\_\_\_

\_\_\_\_\_

Are parents divorced or separated?  No  Yes If yes, how long? \_\_\_\_\_

What are the current custody/visitation arrangements? \_\_\_\_\_

\_\_\_\_\_

**Brothers and Sisters:**

NAME	AGE	OCCUPATION	QUALITY OF RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Describe step-family information, if any:**

NAME	AGE	RELATIONSHIP TO CHILD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has anyone in your child's family had a psychiatric illness?  No  Yes  
 If yes, who and were they hospitalized? \_\_\_\_\_

Has anyone in your child's family attempted suicide?  No  Yes  
 If yes, who? \_\_\_\_\_

Has anyone in your child's family had a seizure disorder?  No  Yes  
 If yes, who? \_\_\_\_\_

Has anyone in your child's family had a problem with or treated for substance abuse problems?  No  Yes  
 If yes, who? \_\_\_\_\_

Has your child ever been physically, sexually or emotionally abused?  No  Yes

Has your child ever had previous psychiatric treatment, counseling or therapy?  No  Yes  
 If yes, was the treatment :  Inpatient  Outpatient

If yes, list names of previous mental health professionals: \_\_\_\_\_

Describe the results of past treatment and the reason for terminating treatment: \_\_\_\_\_

**CURRENT ISSUES:** We would like you to tell us about your child's current problem. Please circle the number which best describes your child on each particular problem.

PROBLEMS WITH SLEEPING	NOT A PROBLEM	MILD PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM
Trouble Sleeping	1	2	3	4
Nightmares	1	2	3	4
Sleep walking	1	2	3	4
Sleep Talking	1	2	3	4
SCHOOL PROBLEMS				
Has problems learning in school	1	2	3	4
Is afraid to go to school	1	2	3	4
Won't obey school rules	1	2	3	4
Often skips school	1	2	3	4
Has conflicts with teachers	1	2	3	4
Performs below his/her ability	1	2	3	4
RELATIONSHIP WITH OTHER CHILDREN				
Picks on other children	1	2	3	4
Has few or no friends	1	2	3	4
Is called weird by other children	1	2	3	4
Plays alone most of the time	1	2	3	4
Fights with other children	1	2	3	4
Has sex play with other children	1	2	3	4
Tries to boss others around	1	2	3	4
BEHAVIOR PROBLEMS				
Uses drugs	1	2	3	4
Runs away from home	1	2	3	4
Uses alcohol	1	2	3	4
Lies	1	2	3	4
Steals	1	2	3	4
Sets fires	1	2	3	4
Breaks things	1	2	3	4
Hurts animals	1	2	3	4
Assault	1	2	3	4

<b>SOCIAL SKILLS</b>	<b>NOT A PROBLEM</b>	<b>MILD PROBLEM</b>	<b>MODERATE PROBLEM</b>	<b>SEVERE PROBLEM</b>
Afraid of many things	1	2	3	4
Very shy	1	2	3	4
Poor loser	1	2	3	4
Demands too much attention	1	2	3	4
Withdraws from people	1	2	3	4
<b>OTHER PROBLEMS WITH RELATIONSHIPS</b>				
Talks back to adults	1	2	3	4
Disobeys parents	1	2	3	4
Can't be trusted	1	2	3	4
Isolates in room	1	2	3	4
Has a "chip" on his/her shoulder	1	2	3	4
Doesn't trust other people	1	2	3	4
<b>EMOTIONAL PROBLEMS</b>				
Is sad or unhappy most of the times	1	2	3	4
Cries a lot	1	2	3	4
Has temper tantrums	1	2	3	4
Mood changes quickly	1	2	3	4
Has lost interest in things	1	2	3	4
Worries a great deal	1	2	3	4
Has difficulty making decisions	1	2	3	4
Has difficulty concentrating	1	2	3	4
<b>OTHER</b>				
Has threatened or attempted to harm self	1	2	3	4
Acts younger than real age	1	2	3	4
Wants things to be perfect	1	2	3	4
Can't sit still	1	2	3	4
Acts without thinking	1	2	3	4
Says or does strange things	1	2	3	4
Daydreams a lot	1	2	3	4
Doesn't finish things	1	2	3	4
Stutters	1	2	3	4
Is easily distracted	1	2	3	4
Bites nails	1	2	3	4
Doesn't speak well	1	2	3	4
Not fully bladder trained	1	2	3	4
Not fully bowel trained	1	2	3	4
Tired most of the time	1	2	3	4
Has aches and pains	1	2	3	4
Clumsy and accident prone	1	2	3	4
Fakes being sick	1	2	3	4
Chronically ill	1	2	3	4

Feel free to list any additional information you feel may be helpful to the clinician who will be working with your child/adolescent:

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Completed by: \_\_\_\_\_ Date: \_\_\_\_\_  
(Please sign your name)

**CLINICIAN ONLY BELOW THIS LINE:**

My signature indicates my review of this information and as appropriate, any abuse and lethality issues with this child/adolescent.

Clinician signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Pre-Treatment Medication Checklist

Please indicate all the medications you have ever been prescribed, include comments on effectiveness and reasons for discontinuing the medication.

ANTIDEPRESSANTS

- Anafranil (Clomipramine) \_\_\_\_\_
- Celexa (Citalopram) \_\_\_\_\_
- Cymbalta (Duloxetine) \_\_\_\_\_
- Desyrel (Trazodone) \_\_\_\_\_
- Effexor, (Venlafaxine) \_\_\_\_\_
- Elavil (Amitriptyline) \_\_\_\_\_
- ENSAM Transdermal Patch (Selegiline) \_\_\_\_\_
- Lexapro (Escitalopram) \_\_\_\_\_
- Luvox, (Fluvoxamine) \_\_\_\_\_
- Nardil (Phenelzine) \_\_\_\_\_
- Norpramin (Desipramine) \_\_\_\_\_
- Pamelor (Nortriptyline) \_\_\_\_\_
- Parnate (Tranlycypromine) \_\_\_\_\_
- Paxil, (Paroxetine) \_\_\_\_\_
- Pristiq (Desvenlafaxine) \_\_\_\_\_
- Prozac; Sarafem (Fluoxetine) \_\_\_\_\_
- Remeron, (Mirtazapine) \_\_\_\_\_
- Serzone (Nefazodone) \_\_\_\_\_
- Sinequan (Doxepin) \_\_\_\_\_
- Surmontil (Trimipramine) \_\_\_\_\_
- Tofranil (Imipramine) \_\_\_\_\_
- Vivactil (Protriptyline) \_\_\_\_\_
- Wellbutrin, (Bupropion)/Zyban \_\_\_\_\_
- Zoloft (Sertraline) \_\_\_\_\_

ANTI-ANXIETY and INSOMNIA MEDICATIONS

- Ambien, (Zolpidem) \_\_\_\_\_
- Ativan (Lorazepam) \_\_\_\_\_
- Benadryl (Diphenhydramine) \_\_\_\_\_
- BuSpar (Buspirone) \_\_\_\_\_
- Dalmane (Flurazepam) \_\_\_\_\_
- Halcion (Triazolam) \_\_\_\_\_
- Klonopin (Clonazepam) \_\_\_\_\_
- Librium (Chlordiazepoxide) \_\_\_\_\_
- Lunesta (Eszopiclone) \_\_\_\_\_
- Noctec (Chloral hydrate) \_\_\_\_\_
- ProSom (Estazolam) \_\_\_\_\_
- Restoril (Temazepam) \_\_\_\_\_
- Rozerem (Ramelteon) \_\_\_\_\_
- Serax (Oxazepam) \_\_\_\_\_
- Sonata (Zaleplon) \_\_\_\_\_
- Tranxene (Clorazepate) \_\_\_\_\_
- Unisom (Doxylamine) \_\_\_\_\_
- Valium (Diazepam) \_\_\_\_\_
- Vistaril, Atarax (Hydroxyzine) \_\_\_\_\_
- Xanax (Alprazolam) \_\_\_\_\_

OTHER MEDICATIONS NOT LISTED ABOVE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

STIMULANT MEDICATIONS

- Adderall \_\_\_\_\_
- Concerta, Daytrana TD Patch, Metadate, Ritalin (Methylphenidate) \_\_\_\_\_
- Dexedrine (Dextroamphetamine) \_\_\_\_\_
- Focalin (Dexmethylphenidate) \_\_\_\_\_
- Provigil \_\_\_\_\_
- Strattera (Atomoxetine) \_\_\_\_\_
- Tenex (Guanfacine) \_\_\_\_\_
- Vyvanse (Lisdexamfetamine) \_\_\_\_\_

MEDICATIONS FOR SIDE EFFECTS

- Artane (Trihexyphenidyl) \_\_\_\_\_
- Benadryl (Diphenhydramine) \_\_\_\_\_
- Cogentin (Benztropine) \_\_\_\_\_
- Inderal (Propranolol) \_\_\_\_\_
- Parlodel (Bromocriptine) \_\_\_\_\_

MOOD STABILIZERS

- Carbatrol, Equetro, Tegretol (Carbamazepine) \_\_\_\_\_
- Depakote, (Divalproic Acid) \_\_\_\_\_
- Eskalith, Lithobid (Lithium) \_\_\_\_\_
- Lamictal (Lamotrigine) \_\_\_\_\_
- Topamax (Topiramate) \_\_\_\_\_
- Trileptal (Oxcarbazepine) \_\_\_\_\_

ANTIPSYCHOTICS

- Abilify, (Aripiprazole) \_\_\_\_\_
- Clozaril, Fazacla (Clozapine) \_\_\_\_\_
- Geodon, (Ziprasidone) \_\_\_\_\_
- Haldol (Haloperidol) \_\_\_\_\_
- Invega (Paliperidone) \_\_\_\_\_
- Loxitane (Loxapine) \_\_\_\_\_
- Mellaril (Thioridazine) \_\_\_\_\_
- Moban (Molindone) \_\_\_\_\_
- Navane (Thiothixene) \_\_\_\_\_
- Prolixin (Fluphenazine) \_\_\_\_\_
- Risperdal, (Risperidone) \_\_\_\_\_
- Serentil (Mesoridazine) \_\_\_\_\_
- Seroquel, (Quetiapine) \_\_\_\_\_
- Stelazine (Trifluoperazine) \_\_\_\_\_
- Thorazine (Chlorpromazine) \_\_\_\_\_
- Trilafon (Perphenazine) \_\_\_\_\_
- Zyprexa, (Olanzapine) \_\_\_\_\_

MEMORY

- Aricept (Donepezil) \_\_\_\_\_
- Exelon (Rivastigmine) \_\_\_\_\_
- Namenda (Memantine) \_\_\_\_\_
- Reminyl (Galantamine) \_\_\_\_\_

