

**Capstone Behavioral Healthcare
Child/Adolescent Information Form**

Date: _____ Child's Social Security Number: _____

Child's Last Name: _____ First Name _____ MI _____

Age: _____ Birthdate: _____

Street Address: _____ City: _____ Zip: _____ Phone: _____

Ethnicity: _____ Gender: ___ Male, ___ Female

Name of person accompanying client today: _____ Relationship to client: _____

Mother's Name: _____ Age: _____ Birthdate: _____

Street Address: _____ City: _____ Zip: _____ Phone: _____

Marital Status: ___ Single, ___ Married, ___ Separated, ___ Divorced, ___ Remarried, ___ Widowed

Name of Mother's Spouse or Partner (if applicable): _____

Father's Name: _____ Age: _____ Birthdate: _____

Street Address: _____ City: _____ Zip: _____ Phone: _____

Marital Status: ___ Single, ___ Married, ___ Separated, ___ Divorced, ___ Remarried, ___ Widowed

Name of Father's Spouse or Partner (if applicable): _____

If parents are divorced/separated, who has legal custody of child? ___ Mother, ___ Father, ___ Joint, ___ Other

By Iowa code and Capstone Behavioral Healthcare, Inc. policy, a standardized letter will be sent to the child's legal guardians, informing them of the child's *mental health* evaluation (and treatment, if recommended) by a clinician.

Who lives in the child's primary home? (Adults and Children)

Name:	Relationship:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who lives in the child's secondary home? (Adults and Children)

Name:	Relationship:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referred by: Self Hospital Family/Friend School Court Physician
 DHS Other _____

Reason for Referral: Mental Health Substance Abuse Zero Tolerance

Briefly describe the problem that brings this child/adolescent to Capstone today: _____

What steps have you already taken to resolve this problem? _____

Please check the behaviors observed and the environment (home or school) where the behavior is seen:

<i>Home</i>		<i>School</i>			<i>Home</i>	<i>School</i>	
<input type="checkbox"/>	<input type="checkbox"/>	Depression/sad thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/nerves		
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks		
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Compulsive behaviors		
<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	Stealing		
<input type="checkbox"/>	<input type="checkbox"/>	Social withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	Racing thoughts		
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Too much energy		
<input type="checkbox"/>	<input type="checkbox"/>	Low energy	<input type="checkbox"/>	<input type="checkbox"/>	Anger		
<input type="checkbox"/>	<input type="checkbox"/>	Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	Aggression/violence		
<input type="checkbox"/>	<input type="checkbox"/>	Running away	<input type="checkbox"/>	<input type="checkbox"/>	Paranoia		
<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices		
<input type="checkbox"/>	<input type="checkbox"/>	Poor attention	<input type="checkbox"/>	<input type="checkbox"/>	Seeing visions		
<input type="checkbox"/>	<input type="checkbox"/>	Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts		
<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Other(s): _____		

Please mark the topic(s) you would like to discuss (& circle any examples that apply to your child):

- Academic concerns:** learning difficulties, anxieties, grades, study skills, motivation
- Adjustment concerns:** assertiveness, loneliness, cultural adjustment, pregnancy, situational stress, grief/loss
- Anxiety/Stress:** fears, nervousness, performance anxiety, school-related anxiety, phobias, panic attacks
- Career concerns:** employment stressors, choosing a career, unemployment/disability, education concerns
- Depression:** sadness, hopelessness, suicidal thoughts or actions, grief over loss/death
- Eating Disorders:** bulimia, anorexia, body image problems, overeating
- Identity Concerns:** self-esteem, gender, ethnic/spiritual identity, sexual orientation
- Physical Problems:** headaches, stomach pains, tension, sleep disturbance, major medical problems
- Relationship Concerns:** conflict, communication, breakup/loss, dealing with friends/family, domestic abuse
- Risky Behavior:** concerns related to sexual behavior, use of alcohol or other drugs
- Traumatic Events:** rape/sexual assault, physical/sexual/emotional abuse, harassment, disaster
- Other** (please explain): _____

Please indicate the degree of seriousness of the concerns you believe your child is dealing with:
 Not very serious 1 2 3 4 5 Very serious/child in crisis

Has the child/adolescent had mental health treatment before? ___ Yes, ___ No

If yes, when & where? _____

Has the child/adolescent had treatment for alcohol or drug use before? ___ Yes, ___ No

If yes, when & where? _____

Has the child/adolescent had any legal involvement? ___ Yes, ___ No

If yes, please explain: _____

Has the child/adolescent been involved with DHS? ___ Yes, ___ No

If yes, please explain: _____

Does the child/adolescent have any current or ongoing medical problems? ___ Yes, ___ No

If yes, please explain: _____

Who is the child/adolescent's primary care physician? _____

Should we contact the child's doctor? ___ Yes, ___ No

What medications does the child/adolescent take? (include non-prescription, herbal medicines & supplements)

Medicine	Dose	Frequency	Who prescribes medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Which pharmacy do you use? _____ Phone: _____

Please list any allergies, including medication allergies/sensitivities: _____

School child is currently attending: _____ Grade: _____

Name of Primary Teacher: _____

Is there any additional information we should be aware of?