

SHODAIR ADMISSION ASSESSMENT FORM



Date: \_\_\_\_\_ Time: \_\_\_\_\_ Intake by: \_\_\_\_\_

Referring party: \_\_\_\_\_ Phone#: \_\_\_\_\_ Email: \_\_\_\_\_

Patient living arrangement:  Parents  Group home  Foster home  JDC  Shelter  Other: \_\_\_\_\_

Patient name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Patient SS#: \_\_\_\_\_ Is youth emancipated, married or had a child?  Yes  No

Name of legal guardian(s):

Father: \_\_\_\_\_ Rights? Yes or No Hm# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Mother: \_\_\_\_\_ Rights? Yes or No Hm# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Other: \_\_\_\_\_ POA or \_\_\_\_\_ Hm# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

DFS or Tribal: \_\_\_\_\_ TIA TLC Full custody Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Assaultive behavior?  No  Yes Suicidal behavior?  No  Yes Is patient an imminent danger to self or others?  
 No  Yes

Reason for Admission: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mental health case manager?  No  Yes Name: \_\_\_\_\_ Phone# \_\_\_\_\_

CSCT organization/Therapist name/Credentials/Ph#: \_\_\_\_\_  
\_\_\_\_\_

Outpatient therapist?  No  Yes  
Name/Credentials/Ph# \_\_\_\_\_

Start Date: \_\_\_\_\_ Last Appt. \_\_\_\_\_ Frequency: Weekly Bi-Monthly Monthly Modality: Individ. Family Group

Previous hospitalizations (Where/when): \_\_\_\_\_

Past psychiatric diagnoses identified: \_\_\_\_\_

Current meds/Doses: \_\_\_\_\_

Meds prescribed by: \_\_\_\_\_ Phone # \_\_\_\_\_

Family doctor/Pediatrician \_\_\_\_\_ Phone # \_\_\_\_\_

Physical health problems?  No  Yes Identify: \_\_\_\_\_

Medication allergies: \_\_\_\_\_ Other allergies: \_\_\_\_\_

Alcohol or drug use? \_\_\_\_\_ Prior treatment provider(s): \_\_\_\_\_

Victim of sexual abuse?  No  Yes History of sexualized behaviors?  No  Yes Describe: \_\_\_\_\_

History of sexual offenses?  No  Yes Prior treatment provider(s): \_\_\_\_\_

Legal history?  No  Yes List: \_\_\_\_\_ Probation officer/Ph # \_\_\_\_\_

Cognitive or developmental delays?  No  Yes Identify: \_\_\_\_\_

Medicaid or insurance? List: \_\_\_\_\_ Subscriber's name/DOB: \_\_\_\_\_

Reviewed by Dr. \_\_\_\_\_ Approved for admit? \_\_\_\_\_ Recommendation:  Acute  Residential/Unit: \_\_\_\_\_

NOT approved: Process # \_\_\_\_\_

What is the legal status of the patient's admission to Shodair? **Voluntary** **Court order**

**IDENTIFYING INFORMATION**

Ethnicity \_\_\_\_\_ Tribe \_\_\_\_\_ Birthplace \_\_\_\_\_

Child's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip code \_\_\_\_\_ Child's phone number: \_\_\_\_\_

Guardian's address (If not parent and if different than child's): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_ Guardian's phone # \_\_\_\_\_

**FAMILY HISTORY**

1) How long were the biological parents together? \_\_\_\_\_  
Are the parents currently: TOGETHER SEPARATED DIVORCED  
If separated/divorced, when did the separation/divorce take place? \_\_\_\_\_

2) Have the parents had additional marriages? **YES NO**  
If "YES", please identify date(s) of marriage(s) and divorce(s): \_\_\_\_\_  
\_\_\_\_\_

3) Does the child have contact with both biological parents?: **YES NO, why?** \_\_\_\_\_  
\_\_\_\_\_

4) Is there any information that cannot be disclosed to the patient at this time? **NO YES (Explain)**  
\_\_\_\_\_

**Is it okay to contact non-custodial parent? YES NO**  
**If no, explain** \_\_\_\_\_

Biological parents married when child was born? **YES NO**  
If not together, date of parental separation (Divorce, breakup, etc.) \_\_\_\_\_

**Name of biological father:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_

1. Parental rights terminated? **NO YES** \_\_\_\_\_
2. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_
3. Phone: Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Wk# \_\_\_\_\_
4. Employer \_\_\_\_\_ Occupation \_\_\_\_\_
5. Level of education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other: \_\_\_\_\_
6. Mental illness, father or family? **NO YES:** \_\_\_\_\_  
\_\_\_\_\_
7. Substance abuse, father or family? **NO YES:** \_\_\_\_\_
8. Any learning disabilities in family? **NO YES:** \_\_\_\_\_
9. Military service history: **NO YES:** \_\_\_\_\_

10. Any previous marriages? **NO YES:** \_\_\_\_\_ # of kids from previous marriage: \_\_\_\_\_

11. How did parent get along with own parents? \_\_\_\_\_

**Name of biological mother:** \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

1. Parental rights terminated? **NO YES** \_\_\_\_\_

2. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

3. Phone: Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Wk# \_\_\_\_\_

4. Employer \_\_\_\_\_ Occupation \_\_\_\_\_

5. Level of education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other: \_\_\_\_\_

6. Mental illness, mother or family? **NO YES:** \_\_\_\_\_

7. Substance abuse, mother or family? **NO YES:** \_\_\_\_\_

8. Any learning disabilities in family? **NO YES:** \_\_\_\_\_

9. Military service history: **NO YES:** \_\_\_\_\_

10. Any previous marriages? **NO YES:** \_\_\_\_\_ # of kids from previous marriage: \_\_\_\_\_

11. How did parent get along with own parents? \_\_\_\_\_

**Other adult involved with patient:** \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to child: **Adoptive parent Step parent Legal guardian Foster parent Or:** \_\_\_\_\_

1. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

2. Phone: Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Wk# \_\_\_\_\_

3. Employer \_\_\_\_\_ Occupation \_\_\_\_\_

4. Level of education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other: \_\_\_\_\_

5. Mental illness, parent or family? **NO YES:** \_\_\_\_\_

6. Substance abuse, parent or family? **NO YES:** \_\_\_\_\_

**Other adult involved with patient:** \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to child: **Adoptive parent Step parent Legal guardian Foster parent Or:** \_\_\_\_\_

1. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home# \_\_\_\_\_ Cell# \_\_\_\_\_

2. Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Wk# \_\_\_\_\_

3. Level of education: Dropped out H.S. Trade Bachelor Master's PhD/MD Other: \_\_\_\_\_

4. Mental illness, parent or family? **NO YES:** \_\_\_\_\_

5. Substance abuse, parent or family? **NO YES:** \_\_\_\_\_

Is there a Guardian Ad Litem involved? Name \_\_\_\_\_ phone# \_\_\_\_\_

Is there any information that cannot be disclosed to the patient at this time? **NO YES:** \_\_\_\_\_

**FAMILY CONSTELLATION:**

Siblings:

(H-Half, F-Full, S-Step, A-Adoptive)

	<u>Name</u>	<u>Gender</u>	<u>Age</u>	<u>Relationship</u>	<u>Residence</u>
1)	_____	<b>M F</b>	____	<b>H F S A</b>	_____
2)	_____	<b>M F</b>	____	<b>H F S A</b>	_____
3)	_____	<b>M F</b>	____	<b>H F S A</b>	_____
4)	_____	<b>M F</b>	____	<b>H F S A</b>	_____

Relationship with siblings: \_\_\_\_\_

How long has the patient lived in the current residency? \_\_\_\_\_

Where else has the patient lived in the past five years? \_\_\_\_\_

Who is currently living in the home? \_\_\_\_\_

Who was responsible for discipline and what was the discipline? \_\_\_\_\_

**CURRENT LEVEL OF FUNCTIONING**

**Behavioral profile**

Describe any suicidal or self-harming behavior: \_\_\_\_\_

Describe any homicidal or assaultive behavior: \_\_\_\_\_

Describe any depression (Onset, duration, provocation): \_\_\_\_\_

Describe any psychotic behavior (Onset, duration, triggers): \_\_\_\_\_

Describe the child's usual mood: \_\_\_\_\_

Describe any mood swings: \_\_\_\_\_

Describe any significant losses: \_\_\_\_\_

Describe any sleep problems (Onset, provocation, frequency): \_\_\_\_\_

Describe any appetite problems (Onset, provocation, frequency): \_\_\_\_\_

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Describe any pyromania (Fire setting): \_\_\_\_\_

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Describe any theft: \_\_\_\_\_

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Describe any cruelty to animals: \_\_\_\_\_

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Describe any verbal abuse/swearing: \_\_\_\_\_

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Describe any history of temper tantrums (Recent? If previous, when they stopped): \_\_\_\_\_

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Describe any destruction of property/vandalism: \_\_\_\_\_

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Describe any enuresis, encopresis, or urinating in inappropriate places: \_\_\_\_\_

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Describe extent of any alcohol use or drug use or smoking: \_\_\_\_\_

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Describe any lying: \_\_\_\_\_

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Describe any running away: \_\_\_\_\_

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Describe any poor hygiene: \_\_\_\_\_

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Describe any impulsive behavior (Doing without thinking): \_\_\_\_\_

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Describe any problems with memory or concentration (Onset): \_\_\_\_\_

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Describe any risky behavior: \_\_\_\_\_

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Describe any problems playing with others (Is child invited to others' houses for day, overnight?): \_\_\_\_\_

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Describe any problems with peer group (What is typical relationship like with peers?): \_\_\_\_\_

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Describe any inappropriate sexual behavior (Public masturbation, fondling, exposing self, etc.): \_\_\_\_\_

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How has the family reacted to the patient's problems? \_\_\_\_\_

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**PAST TREATMENT HISTORY**

Where has the patient received therapeutic services in the past? (Most recent first, **I**-Inpatient, **O**-Outpatient)

	<u>Name of Agency/Therapist</u>	<u>Dates</u>	<u>Level</u>	<u>Primary Referring Problem(s)</u>
1)	_____	_____	I O	_____
2)	_____	_____	I O	_____
3)	_____	_____	I O	_____
4)	_____	_____	I O	_____
5)	_____	_____	I O	_____

**Other services received:** (and reasons previous services were stopped)

Case management: \_\_\_\_\_

In-home family based services/dates: \_\_\_\_\_

Parenting classes/dates: \_\_\_\_\_

Neurological evaluations/dates: \_\_\_\_\_

Any prior psychological testing? **NO YES**

When: \_\_\_\_\_ Where: \_\_\_\_\_ By whom: \_\_\_\_\_

Why: \_\_\_\_\_ I.Q. \_\_\_\_\_

**Previous DSM IV diagnosis indicated:**

Is this diagnosis from: **Shodair Other:** \_\_\_\_\_ Date: \_\_\_\_\_

AXIS I: \_\_\_\_\_

AXIS II: \_\_\_\_\_

AXIS III: \_\_\_\_\_

AXIS IV: \_\_\_\_\_

AXIS V: GAF= \_\_\_\_\_

**CHILD'S DEVELOPMENTAL HISTORY**

Child's current height \_\_\_\_\_ Child's current weight \_\_\_\_\_

Problems during pregnancy/birth? **NO YES:** \_\_\_\_\_

Any history of prenatal substance exposure?: **NO YES:** \_\_\_\_\_

Any history of postpartum depression? **NO YES:** \_\_\_\_\_

When did the child start walking? \_\_\_\_\_ Talking? \_\_\_\_\_ Toilet trained? \_\_\_\_\_

Any periods where child regressed? **NO YES:** \_\_\_\_\_

Any negative responses to separation from parents, feeding schedules, change? **NO YES** \_\_\_\_\_

Medical/accidents? **NONE PROB:** \_\_\_\_\_

Any behavior or temperament problems? **NO YES:** \_\_\_\_\_

**NEGLECT AND ABUSE HISTORY**

Any history of physical abuse? **NO YES?** \_\_\_\_\_

Any history of sexual abuse (including rape)? **NO YES?** \_\_\_\_\_

Any history of neglect? **NO YES?** \_\_\_\_\_

Any exposure to violence (movies or domestic violence)? **NO YES:** \_\_\_\_\_

Has Social Services ever investigated the family or patient? **NO YES**

<u>When?</u>	<u>Why?</u>	<u>Findings/Result of investigation</u>
1) _____	_____	_____
2) _____	_____	_____

**EDUCATIONAL HISTORY**

Current school: \_\_\_\_\_ Current grade: \_\_\_\_\_

Name of primary school contact: \_\_\_\_\_

Special education services or 504 plan? **NO YES:** \_\_\_\_\_

Learning disabilities? **NO YES:** \_\_\_\_\_

Peer/teacher relations? \_\_\_\_\_

Preferred learning method: **Visual Auditory Tactile**

Recent school performance (Grades, behavior): \_\_\_\_\_

Number of days of school missed in past year?	<b>0-5</b>	<b>6-10</b>	<b>11-15</b>	<b>&gt;15</b>
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**ENVIRONMENTAL AND CULTURAL FACTORS**

**Cultural and spiritual needs/issues**

Spiritual affiliation? \_\_\_\_\_

Active in cultural or spiritual activities? **NO YES:** \_\_\_\_\_

Cultural/environmental factors impeding accessibility to treatment? **NO YES:** \_\_\_\_\_

**Leisure/recreation interests**

What are the patient's interests/hobbies? \_\_\_\_\_

Hours of TV, video games, computer per week?	<b>&lt;10</b>	<b>11-24</b>	<b>&gt;25</b>
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**Environmental needs**

Patient has stable housing? **YES NO:** \_\_\_\_\_

Neighborhood safe? **YES NO:** \_\_\_\_\_

**Discharge placement after residential treatment:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of person completing this form**

\_\_\_\_\_  
**Date**