PINE REST Christian Mental Health Services

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) 258-7500 or (866) 852-4001. Thank you.

PINE REST Christian Mental Health Services

MR# _____

Dear Parent: To help your clinician understand and help your child, please answer the questions on this form and bring it with you to your child's first appointment.

**Child's Legal Name:** _____ Date of birth: _____

Form completed by: _____ Relationship to child: _____

Did anyone refer you to Pine Rest?_____ Today's date:_____

## PRESENTING PROBLEM/REASON FOR TREATMENT

What is your primary reason for having your child come to Pine Rest?_____

_____

Please check any concerns you may have about your child in the boxes below :

| | | |
|---|---|---|
| □ Sad or unhappy most of the time<br>□ Cries a great deal<br>□ Decreased energy<br>□ Feelings of being worthless/helpless<br>□ Apathy—doesn't seem to care<br>□ Frequently negative thinking<br>□ Thoughts of suicide or self-harm<br>□ Angry/easily irritated | □ Temper tantrums<br>□ Lies<br>□ Swears<br>□ Has a "chip" on his/her shoulder<br>□ Talks back to adults<br>□ Disobeys parents<br>□ Can't be trusted<br>□ Dependent/needs a lot of reassurance | □ Bites nails/pulls own hair<br>□ Lots of aches and pains<br>□ Stutters or doesn't speak well<br>□ Trouble sleeping<br>□ Nightmares<br>□ Sleep walking/talking<br>□ Not fully bladder/bowel trained<br>□ Self-mutilates |
| □ Afraid of many things<br>□ Very shy<br>□ Panic attacks<br>□ Avoids going places/being with others<br>□ Excessive anxiety concerning separation from home or parents<br>□ Checks things repeatedly<br>□ Needs things to be perfect<br>□ Excessive or senseless worries<br>□ Lacks confidence in abilities | □ Picks on other children<br>□ Tries to boss others around<br>□ Has few or no friends<br>□ Is called weird by other children<br>□ Plays alone most of the times<br>□ Fights with other children<br>□ Sensitive to criticism<br>□ Afraid of rejection<br>□ Poor loser<br>□ Doesn't trust other people | □ Significant recent weight or appetite changes<br>□ Can't always seem to separate what is pretend from what is real<br>□ Hearing voices/seeing things<br>□ Rapid mood changes without cause<br>□ Victim of bullies<br>□ Exhibits sexually inappropriate behaviors<br>□ Gender identity concerns |
| □ Concentration difficulties<br>□ Daydreams<br>□ Needs lots of reminders<br>□ Doesn't finish things<br>□ Can't sit still/very active<br>□ Acts without thinking<br>□ Easily distracted<br>□ Demands too much attention | □ Has problems learning in school<br>□ Hates going to school<br>□ Seems afraid of going to school<br>□ Won't obey school rules<br>□ Often skips school<br>□ Has conflicts with teachers<br>□ Performs below his/her ability<br>□ Problems with homework | □ Immature<br>□ Concerns with alcohol or drug use<br>□ Runs away from home<br>□ Steals<br>□ Sets fires<br>□ Breaks things<br>□ Cruel to animals<br>□ Has been victim of abuse |

Are there other concerns (not listed above) that you want to discuss?_____

_____

How have these concerns impacted your child's daily life?_____

_____

Is there anyone that you want Pine Rest to be working with regarding your child's treatment (i.e.: teacher, pediatrician, probation, court)? _____

MR # _____

## RACE/ETHNICITY (OPTIONAL)

**Race**: □ American Indian or Alaska native □ Asian □ Black or African American □ Hispanic/Latino
□ Native Hawaiian or Other Pacific Islander □ Two or more races □ White

**Ethnicity**: □ Hispanic or Latino □ Not Hispanic or Latino

## YOUR CHILD'S FAMILY AND SUPPORTIVE RELATIONSHIPS

Are parents divorced or separated? ❑ No ❑ Yes

If yes, how long? _____

What are the current custody/visitation arrangements? _____

_____

Please tell us about the household/family with whom your child spends the majority of his/her time (or who currently lives with your child). List primary household information first, then list other living situations/supportive relationships:

| Name of Family Member | Age | Relationship (e.g. Father, Mother, Brother, Sister, Step-Sibling, Aunt, Uncle) | Quality of Relationship | Living with you? |
|---|---|---|---|---|
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |
| | | | □ Good □ Fair □ Poor | □ Yes □ No |

Do you have significant concerns about your child's relationship with a family member? ❑ No ❑ Not sure ❑ Yes
(e.g.: sibling, step-parent, extended family)

If so, please describe your concerns_____

_____

## YOUR CHILD'S BIRTH AND EARLY DEVELOPMENT

Is this child adopted? ❑ No ❑ Yes If yes, at what age? _____

Were there any complications with the pregnancy of this child that might have impacted his/her prenatal health or development? (e.g.: mother had significant illness, smoked cigarettes, drank alcohol, experienced severe bleeding, etc.)
❑ No ❑ Yes

Were there significant problems with this child's health or development in the first few years of his/her life? (e.g.: needed to be revived at birth, failure to thrive, missed significant developmental milestones)
❑ No ❑ Yes

If yes, please explain: _____

_____

**If necessary, your therapist may ask you to complete a more extensive history of your child's early development.**

## YOUR CHILD'S LIFE STORY

What are a few areas where your child excels? (e.g.: personal strengths, favorite things to do) _____

_____

**EDUCATIONAL HISTORY:**

Where does your child attend school? _____

What is the highest grade level of school your child has completed? _____

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

What have been your child's most recent grades? _____

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: _____

**PREVIOUS COUNSELING TREATMENT HISTORY:**

Has your child ever received previous counseling, therapy, or psychiatric treatment? ❑ No ❑ Yes

If yes, can you please describe: (When, where, for what purpose, the results, and reason for terminating treatment)

| When | Where | Name of Mental Health Professional | Purpose of treatment | Results | Reason for terminating treatment |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

MR # _____

**ABUSE HISTORY**

Has your child ever been the victim of abuse or neglect? ❑ No ❑ Yes

If yes, was the abuse: ❑ Physical ❑ Sexual ❑ Emotional ❑ Neglect ❑ Verbal

**LEGAL HISTORY:**

Please list any contacts your child has had with the courts (including Friend of the Court): _____

_____

Please list any contacts your child has had with the police (or Child Protective Services):_____

_____

**TOBACCO USE HISTORY:**

Has your child ever: Used chewing tobacco? ❑ No ❑ Yes Smoked? ❑ No ❑ Yes

Explain any 'Yes" answers above (including if daily or occasional use)_____

_____

**SUBSTANCE USE HISTORY:**

Has your child ever had a problem with alcohol or other drugs? ❑ No ❑ Yes

Explain any 'Yes' answers above: _____

_____

**SPIRITUAL DEVELOPMENT:**

What is your child's present religious affiliation? _____

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

Describe _____

## MEDICAL HISTORY

Does your child have any current medical concerns?_____

_____

Does your child have problems with pain? □ Yes □ No

Severity of pain? (low) 1 2 3 4 5 6 7 8 9 10 (high)

Location of pain?_____

Has your child had any past surgical procedures? ❑ No ❑ Yes

If yes, list: _____

Has your child been exposed to any contagious diseases such as Tuberculosis? ❑ No ❑ Yes

If yes, to what and when did the exposure take place? _____

Are immunizations current? ❑ No ❑ Yes

Please list all current medications and/or supplements your child is currently taking:

(attach another page if needed, or bring a list to your appointment)

| Name of Medication | Dosage/Amount | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Has your child ever had an allergic reaction to medication(s)? ❑ No ❑ Yes

Name of medication Explain reaction:

_____ _____ _____

_____ _____

MR # _____

## FAMILY/MEDICAL HISTORY

Biological Father's Name: _____ Age: _____ Education: _____

Occupation: _____ Deceased? ❑ No ❑ Yes If yes, when? _____

Description of relationship between father and child: _____

Biological Mother's Name: _____ Age: _____ Education: _____

Occupation: _____ Deceased? ❑ No ❑ Yes If yes, when? _____

Description of relationship between mother and child: _____

Has anyone in your child's extended family (ex: parent, grandparent, uncle/aunt) had a psychiatric illness? ❑ No ❑ Yes

If yes, please describe to the best of your ability (Who, symptoms/diagnosis, 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 problem with or treated for substance abuse problems? ❑ No ❑ Yes

If yes, who? _____

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

_____

_____

_____

_____

Completed by: _____ Date: _____

(Please sign your name)

**THANK YOU!**

PINE REST Christian Mental Health Services

Name: _____

MR#: _____
(office use only)

# 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 (Tranylcypromine)_____
- ☐ 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, Fazaclo (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) _____