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.
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
- Cries a great deal
- Decreased energy
- Feelings of being worthless/helpless
- Apathy—doesn’t seem to care
- Frequently negative thinking
- Loss of interests—doesn’t enjoy things
- Thoughts of suicide or self-harm
- Angry/easily irritated
- Afraid of many things
- Very shy
- Panic attacks
- Avoids going places/being with others
- Checks things repeatedly
- Needs things to be perfect
- Sensitive to criticism
- Excessive or senseless worries
- Lacks confidence in abilities
- Dependent/needs a lot of reassurance
- Unorganized
- Takes forever to do things
- Needs things to happen right now
- Problems with homework
- Demands too much attention
- Conscientious
- Is easily distracted
- Daydreams
- Forgets things
- Needs lots of reminders
- Doesn’t finish things
- Can’t sit still/very active
- Acts without thinking
- Takes time to think
- Resourceful
- Extremely intelligent
- Easily frustrated
- Does not adapt well
- Poor recognition of others’ feelings
- Frequently negative thinking
- Apathy
- Acts with little regard for others
- Sees himself/herself as special
- Difficult to understand
- Difficult to know what she/he needs
- Difficult to soothe
- Unpredictable
- Seems pampered
- Bites nails/pulls own hair
- Needs things to be perfect
- Checks things repeatedly
- Avoids going places
- Panic attacks
- Very anxious
- Afraid of rejection
- Doesn’t trust other people
- Sees herself/himself as bad
- Balloon
- Characteristics of others
- Sees others as mean
- Current mood
- Pets
- Bites
- Temper tantrums
- Frequently Lies
- Frequently Swears
- Talks back to adults
- Is aggressive/confrontational to adults
- Rarely follows instructions
- Can’t be trusted
- Unmotivated
- Runs away from home
- Picks on other children
- Tries to boss others around
- Has few or no friends
- Is seen as weird or different by peers
- Isolates self away from others
- Poor loser
- Afraid of rejection
- Doesn’t trust other people
- Victim of bullies
- Physical fights with other children
- Has problems learning in school
- Hates going to school
- Seems afraid of going to school
- Difficulty following school rules
- Often skips school
- Has conflicts with teachers
- Performs below his/her ability
- Problems with homework
- Exhibits inappropriate sexual behavior
- Trouble with knowing what is real
- Demonstrates bizarre behavior (e.g.: hearing voices/seeing things)
- Rapid mood changes without cause
- Extreme risk taking or impulsivity
- Recurrent intrusive thoughts
- Cruel to animals
- Immature
- Dating problems
- Concerns with alcohol
- Concerns with drug use
- Has been in trouble with the law
- Has had problems with pornography
- Steals
- Breaks things
- Has used a weapon
- Has been the victim of abuse
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- Has used a weapon
- Has been the 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 (e.g.: teacher, pediatrician, probation, court)? ____________________________________________
MR # _____________

**RACE/ETHNICITY (OPTIONAL)**

Please check the box that best represents your race/ethnic background:

☐ American Indian or Alaska native  ☐ Asian  ☐ Black or African American  ☐ Hispanic  
☐ Native Hawaiian or Other Pacific Islander  ☐ Two or more races  ☐ White

**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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship (e.g. Father, Mother, Brother, Sister, Step-Sibling, Aunt, Uncle)</th>
<th>Quality of Relationship</th>
<th>Living with you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Good □ Fair □ Poor</td>
<td>Yes □ No</td>
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<td>Yes □ No</td>
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</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>When</th>
<th>Where</th>
<th>Name of Mental Health Professional</th>
<th>Purpose of treatment</th>
<th>Results</th>
<th>Reason for terminating treatment</th>
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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
Has your child ever been the perpetrator of abuse?  ☐ No  ☐ Yes
If yes, was the abuse:  ☐ Physical  ☐ Sexual  ☐ Emotional  ☐ 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):
________________________________________________________________________________________________

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?________________________________________________________
________________________________________________________________________________________________

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)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage/Amount</th>
<th>Frequency</th>
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</table>

Has your child ever had an allergic reaction to medication(s)?  ☐ No  ☐ Yes
Name of medication
___________________________________________
Explain reaction:
___________________________________________
___________________________________________
___________________________________________
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: ______________________________________________________________
(Please sign your name) Date: ______________

THANK YOU!
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)
- Pamelo (Nortriptyline)
- Parnate (Tranylcypromine)
- Paxil, (Paroxetine)
- Pristiq (Desvenlafaxine)
- Prozac, Sarafem (Fluoxetine)
- Remeron, (Mirtazapine)
- Serzone (Nefazodone)
- Sinequan (Doxepin)
- Seroquel, (Risperidone)
- Tofranil (Imipramine)
- Tofranil (Imipramine)
- Vivactil (Protriptyline)
- Wellbutrin, (Bupropion)/Zyban
- Zoloft (Sertraline)

### Antianxiety and Insomnia/Zyban
- 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 (Rameloxone)
- Serax (Oxazepam)
- Sonata (Zaleplon)
- Tralatone (Clorazepate)
- Unisom (Doxylamine)
- Valium (Diazepam)
- Vistaril, Atrax (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
- Carbretol, 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)

### Memory
- Aricept (Donepezil)
- Exelon (Rivastigmine)
- Namenda (Memantine)
- Reminyl (Galantamine)