St. Luke's Hospital
Children's Specialty Services
Intake Form

Child Name: ______________________________ **Today's Date:** ________________

Child's Date of Birth: ______________________

Form filled out by: ________________________ **Relationship to child:** __________

Is this child court ordered to this program? **Yes** **No**

Child lives with (name and relationship): ____

Parent/Guardian: ______________________________________

Address: ____

Home phone: ______________________ Work phone: ________________________

Cell phone: ________________________ Email address: ______________________

Employer: _________________________ Occupation: ________________________

Parent/Guardian: ______________________________________

Address: ____

Home phone: ______________________ Work phone: ________________________

Cell phone: ________________________ Email address: ______________________

Employer: _________________________ Occupation: ________________________

Child/Teenager's Cell phone: ____

Others living in the household:

Name	Age	Relationship to Child

Child/Family Strengths:

Describe a situation when your child does best or feels most successful: ____________________

____

____

What does your child enjoy doing when given free time? ____________________________

____

____

Describe your child's strengths: ____

____

____

Describe your family's strengths: ____

____

____

Family/Peer Relationships

Describe your relationship with your child: _______________________________________

____

____

Describe your family's communication and interactions: (open, tense, loving, caring stressed, etc.) and explain: ____

____

____

Describe spousal relationship, if applicable: _______________________________________

____

Current family stressors: ____

____

____

Describe your child's peer relationships (number of friends, quality of friendships, any difficulties etc.):_

____

School Information:

School Name: ______________________________ Grade: __________

Type of Classroom: (general education, BD, resource, etc.) ______________________________

Teacher or Contact person: ______________________________

Phone number: ______________________________

Brief description of your child's strengths and concerns at school: ______________________________

Mental Health History

Outpatient Counselors (please list current and past therapist/counselors and their phone numbers):

Previous Therapists: ______________________________

Current Therapists: ______________________________

Has your child ever been hospitalized on a psychiatric unit? Please list when and where: _____

Has your child ever been in an alternative placement? (Residential facility, PMIC, foster care, etc. Please list location and dates of placement)______________________________

Is there current DHS involvement? Please list name and phone number of worker: __________

Is your child involved with Juvenile Court? Please list name and phone number of JCO or Tracker:

____

____

Other Services: (Remedial Worker, other support workers): ______________________

____

Family History of Substance/Mental Health Concerns

Is there a history of drug or alcohol abuse with child's mother or mother's immediate family? Please list: ____

____

Is there a history of mental illness with child's mother or her immediate family? (for example: depression, anxiety, ADHD, etc.) Please list: ____________________________________

____

____

Is there a history of drug or alcohol abuse with child's father or his immediate family? Please list:

____

____

Is there a history of mental illness with child's father or his immediate family? (for example: depression, anxiety, ADHD, etc.) Please list: ____________________________________

____

____

Behavioral History

Describe past incidents of aggressive/assaultive behavior in the community, home or at school:

____

____

____

Describe recent incidents of aggressive/assaultive behavior in the community, home or at school:

____

____

____

Describe what it looks like when your child becomes angry or upset (ie: runs away, hits, kicks etc.):

____

____

____

____

What typically triggers your child to become angry or upset?: ____________________

____

____

Has your child ever attempted suicide or made suicidal threats? Please describe: ________

____

____

Has your child been sexually abused? If yes, please share when, who was the perpetrator and has your child received counseling as a result? ____________________

____

____

Has your child displayed any sexual acting out behaviors toward others? (ie: touched other children inappropriately, expressed inappropriate sexual thoughts or desires etc.) ________

____

____

Does your child express any obsessions, delusions or homicidal thoughts/gestures? If yes, please explain: ____________________________________

____

Has your child ever had hallucinations? If yes, please describe: ____________________

____

____

Has your child been physically abused? If yes, please describe: ____________________

____

____

Has your child experience neglect? If yes, please describe: ____________________________

____

____

Has your child witnessed domestic violence in the home? If yes, please describe: ___________

____

____

Does your child have access to firearms or other weapons in your home, a friend's home or a relative's home? If yes, please explain: ____

____

Health History

Medical Doctor Name and Phone Number: ____

Psychiatrist Name and Phone Number: ____

Are Immunizations up to date? Yes No

Please describe any current medical problems/concerns (asthma, diabetes, seizures, etc): ____

____

____

Describe past health history. Please list any past hospitalizations, surgeries, serious illnesses or injuries, head injuries or loss of consciousness: ___________________________________

____

____

Does your child have hearing difficulties? If yes please explain: _______________________

Does your child where glasses or contacts? Yes No

How is your child's appetite? (please circle) Good Fair Variable

Does your child require a special diet? If yes, please explain: _________________________

Does your child have any problems with elimination? (ie: wets the bed, soils self, requires laxatives etc.) ____

____

On average, how many hours does your child sleep each night? ______________________

Does your child have problems with nightmares, night terrors, sleep walking? ____________

____

Do you have any concerns about your child's sexual development? __________________

Is your child sexually active? Yes No

Has your child had a sexually transmitted disease? Yes No

Is your child questioning his/her sexual identity? If yes, please describe: _______________

____

How is your child's oral health? Good Fair Poor

How is your child's self-care/hygiene? Good Fair Poor

Does your child have a history of using drugs or alcohol? If yes please explain: ___________

____

Is there tobacco use in the home? If yes, please explain: __________________________

____

Is your child compliant with taking medications? Yes No

Do you have any concerns about the medications your child is taking? _________________

____

Occupational Therapy Screen

Does your child appear to be seeking movement, touch or deep pressure (examples include spinning, rocking, consistently seeking hugs, biting arms or hands, putting non-food items in mouth, head banging, pulling own hair, heavy walking, etc.)? **Yes** **No**

Is your child bothered by noise (crowds, loud voices, sirens, vacuums, etc.), touch (from others, tags in shirts, seams in socks, avoids being messy, expresses distress with bathing, toothbrushing, etc.) and/or bright/fluorescent lights? **Yes** **No**

Has your child ever seen an Occupational Therapist for sensory concerns? **Yes** **No**

Physical Therapy/Functional Screen

Does your child have any difficulties with the following: Walking on carpet or uneven ground, sitting, standing, getting out of bed, bathing, toileting, running, skipping, kicking balls, catching balls, riding a bike, jumping rope or hopping? (circle all that apply) Please explain: _________

____

Spirituality Screen

Are you currently practicing a religion? Yes No

Is there anything related to your religion that will interfere with your child's treatment? Yes No
Please explain: ____________________

Nutritional Screen

Circle only those numbers that apply	YES		YES
My child follows a special diet. If yes, describe the diet: ________	3	Sometimes my family doesn't have enough money to buy the food I need.	1
Most of the time my child eats supper alone.	2	My child takes two or more different medicines each day. (prescribed or over-the-counter)	1
My child is pregnant or nursing a baby.	6	Child or Parent/guardian is worried about the child's weight.	3
My child has tooth or mouth problems that make it hard to eat.	2		
		Total the Score **If 0-5 You are at low nutritional risk** **If 6+ You are at high nutritional risk**	☐

Has your child had any recent weight gain or loss, changes in appetite, or smokes cigarettes?
Please explain any yes answers to these questions. ____________________

____

Speech Screen

Does your child have any speech or language delays? Yes No

Is your child currently receiving speech therapy? Yes No

Can your child follow one, two and three step directions? Yes No

Can your child state the steps to performing a task
(ie: How do you make a peanut butter and jell sandwich?) Yes No

Can your child sequence events?
(ie: What did you do last night? First, second, third?) Yes No

Can your child generate a simple story with a beginning, middle, and an end? Yes No

Cultural Screen

Is there anything related to your cultural beliefs that will interfere with your child's treatment?

Yes No If yes, please explain: ____________________

Pain Screen

Does your child have consistent pain? Yes No

If yes, what is the frequency of the pain? ____

What is the location of the pain? ____

How long have they had this pain? ____

What makes the pain worse/better? ____

Does this pain affect the following? Circle all that apply: *Sleep* *Appetite*

Concentration *Emotions* *Physical Ability* *Social Relationships*

On a scale of 1-10 (1 = very low intensity – 10 = very high intensity) how intense is the pain? ______

Educational Screen

Does your child have academic concerns at school? If yes, please explain: ________________

____

What is your child's level of interest in learning new things? Circle all that apply:

Expresses a desire for learning *Indicates disinterest for learning*

Not able to concentrate *Concentrates for brief periods of time* *Other:*____________

What is your child's preferred learning style? Please circle all that apply: *Discussion*

Videos *Information sheets* *Computer* *Hands on activities*

Would you or your child like more information on any of the following? Circle all that apply:

Medications *Diagnosis* *Community Resources* *Anger management*

Developmental Needs *Food/Drug Interactions*

Please describe in detail what has led you to seek assistance in this program at this time:

____

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