CentraCare™

Clara's House PHP

1564 County Road 134
St. Cloud, MN 56303

Phone 320-229-4950
Fax 320-229-4999

Greetings!

Your child has been referred to Clara's House Partial Hospitalization Program. Included with this letter is a Confidential Referral Form, "What to Expect" flyers, Parental Support Agreement, Release of Information forms, and a Behavioral Health Intake Form. Reviewing and completing these documents is the critical first step in ensuring that your child receives the high-quality care that Clara's House is known for. Listed below are some additional documents that we also need in order to move forward with the referral process.

Please have a professional working with your child complete the Confidential Referral Form. Additionally, sign the Parental Support Agreement form, complete the Behavioral Health Intake Form, and gather the additional documents listed below (if applicable). We have also included Release of Information forms with this letter for your convenience. If you are unable to retrieve the requested documents yourself, let us do it for you. All you have to do is provide us with a signed Release of Information form so that we can request to access the records on our own. Lastly, please make sure that we receive this information in a timely manner, so we can begin providing care for your child as soon as possible.

___ Confidential Referral Form (included with this letter)
___ Parental Support Agreement (included with this letter)
___ Release of Information forms (included with this letter)
___ Behavioral Health Intake Form (included with this letter)
___ IEP information and the accompanying Evaluation Report (from your child's school)
___ Diagnostic Assessment and 3-4 recent progress notes (from your child's therapist)
___ Psychiatric Assessment and 3-4 recent progress notes (from your child's psychiatrist)
___ Psychological Evaluation Report (if your child has completed any psychological testing)

We are happy to provide any assistance you may need with the task of gathering these documents. Please feel free to call us or send an email. You may email or fax any of the documents directly to us. You can also drop them off in person at Clara's House (located at 1564 County Road 134, St. Cloud, MN 56303). We appreciate the time and effort put into completing this step, and we look forward to working with you and your child!

Sincerely,

Dani and Jamie
Administrative Assistants
(320) 229-4950
ClarasHousePHP@centracare.com

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St. Cloud Hospital
Clara's House | A Place of Healing & Hope
1564 County Road 134 | St. Cloud, MN 56301

Confidential Referral Form (to be completed by referent)

Clara's House Phone: 320-229-4950; Fax: 320-229-4999
Email Address: ClarasHousePHP@centracare.com

Referral Agency: ___________________________ Referral Date: __________________
Staff Person: ______________________________
Contact Information: ______________________

Child Name (First, MI, Last)	**Age:**	**Date of Birth:**
School:	**Grade:**	**Gender:**
Parent's name:		**Phone:**
Address:	**City:**	**State:**
Parent's name:		**Phone:**
Address:	**City:**	**State:**

List all people this child/adolescent is currently living with:

Name	Age	Relationship

Mental Health Treatment History	**Name of Provider, Place(s) and Date(s)**
☐ Psychiatry	
☐ Therapy/Counseling	
☐ Inpatient Hospitalization	
☐ Partial Hospitalization	
☐ Day Treatment	
☐ Chemical Dependency Treatment	
☐ In-Home Family Therapy/Skills	
☐ Psychological Testing	

Reasons for Referral

Current Diagnoses: ____

____

Current Behavioral/Emotional Issues:

Physical Aggression			YES	NO
Verbal Aggression			YES	NO
Destruction of Property			YES	NO
Running Away			YES	NO
Suicidal Thoughts/Actions			YES	NO
School Difficulties			YES	NO
Family Issues			YES	NO
Alcohol/Chemical Use			YES	NO
Bedwetting/Encopresis			YES	NO
Sexualized Behavior			YES	NO
Past or Current Abuse	Past	Ongoing	YES	NO
Physical	______	______		
Emotional	______	______		
Neglect	______	______		
Sexual	______	______		

******Please attach the following information in order to expedite the referral******

A recent Diagnostic/Psychiatric Assessment in addition to 3-4 recent psychotherapy or psychiatry progress notes. You may also send any other information that would support the referral such as a Psychological Evaluation report, IEP information, and the accompanying Evaluation Report. Once the information has been received the referral will be reviewed, and if approved, the family will be contacted regarding an admission date.

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What to Expect When Your Child is at Clara's House

What is Clara's House/Partial Hospitalization?
Clara's House is a behavioral health treatment program with the goals of assessing and stabilizing severe symptoms of depression, anxiety, impulsivity, and behavioral problems. Patients are generally divided into three age groups:

- Child: 5 to 9 years old (grades K-4)
- Early Adolescent: 10 to 14 years old (grades 5-8)
- Adolescent: 15 to 18 years old (grades 9-12)

What are the program hours of Clara's House?
Monday–Friday, 8:00am–3:00pm during the school year, and 8:00am–2:00pm in the summer.

How long will my child be at Clara's House?
Children generally participate in the program about 3 to 6 weeks. Insurance issues can sometimes suddenly impact the length of stay.

What will my child do at Clara's House?
Your child will be participating in many types of group therapy including: psychotherapy group, skills group, yoga/mindfulness group, art therapy, and recreational therapy. Patients on the Child Unit participate in occupational therapy as well. Additionally, your child will meet individually with his or her therapist and attend weekly family therapy sessions. Your child will also meet with a psychiatry provider two times per week for ongoing care and evaluation. The provider directs patient care and manages any medication that your child may be taking.

What will my child learn from all this?
Your child will learn how to regulate his or her emotions and understand why this regulation is important. Your child will also grow in his or her understanding of how therapy works, which will make outpatient appointments more effective. Your child will begin to understand and apply a variety of strategies such as mindfulness, coping skills, communication skills, and anger management skills. Most significantly, it is likely that your child will experience an increase in self-esteem and self-acceptance while at Clara's House.

Who will be caring for my child?
Your child will become part of a small group that includes peers of similar age in addition to a core group of staff. The staff on each unit function as a multidisciplinary team including psychiatry providers, psychotherapists, nurses, a Program Facilitator, Behavioral Health Associates, a classroom teacher, and a paraprofessional. Specialty staff, who work with children from each of the units, consist of art therapists, a recreational therapist, yoga/mindfulness therapist, occupational therapist, and occupational therapist assistant.

What is expected of parents when their child is at Clara's House?

- Participate in the admission process which lasts about 2-3 hours (this can be shorter or longer depending on complexity).
- Complete and return the mandatory communication sheet daily.
- Return phone calls as quickly as possible.
- Ensure that your child attends programming each day as daily attendance is mandatory. If your child is ill, please call the unit nurse to discuss this.
- Share concerns, ask questions, and let staff know what would help your child.
- Engage your child by asking about his or her day at Clara's House and review/reinforce what your child is learning about.
- Participate in family therapy sessions weekly, as family involvement is critical for optimal care.
- Attend a discharge planning meeting toward the end of your child's stay that can include staff from your child's school and any other professionals that may be involved in your child's life.

What about my child's education while at Clara's House? Education is provided by St. Cloud School District 742. Clara's House collaborates with District 742 so that education is provided during the programming day. Your child will participate in two

hours of classroom time each day that school is in session (according to the District 742 academic calendar). The teacher at Clara's House will be in contact with you and/or the appropriate school staff to help determine the educational topics that your child will focus on while at Clara's House.

How is transportation handled at Clara's House?
In most cases, your child's home school district is responsible for providing transportation for your child during his or her time at Clara's House. The teachers at Clara's House will help with these arrangements. This process can sometimes take a few days to be completed. **Therefore, parents are responsible for arranging or providing transportation for their child to and from Clara's House until school transportation is in place.** Additionally, Clara's House is a hospital program which means it is open on non-school days. Parents are responsible for arranging or providing transportation for their children to and from Clara's House on non-school days when the school district does not usually provide transportation. For example, school districts will not provide transportation in the summer months.

Can my child continue to see his or her therapist and/or psychiatry provider while at Clara's House?
Unfortunately, no. Insurance typically only covers the services of one provider and one therapist at a time. However, know that your child will be seen regularly by a psychiatry provider and therapist throughout the duration of his or her stay at Clara's House. Please put outside psychiatric, therapy, and skills appointments on hold while your child is at Clara's House.

Why is my child's Clara's House binder/tool bag important? Each patient on the Adolescent Unit and Early Adolescent Unit is given a binder to help organize the information they receive from Clara's House staff. Patients on the Child Unit will receive a Clara's House tool bag that contains fidgets and other helpful calming tools. Patients are introduced to a lot of new information, so having these materials helps them teach family members what they are learning about in addition to providing a good review for your child after discharge.

What can my child bring to Clara's House?
Patients should have their Clara's House binder and completed communication sheet each day. A jacket, hat, gloves, boots, and snow pants may also be necessary. There is a gym at Clara's House, so tennis shoes are helpful. Electronic devices will be secured upon arrival and returned for use at the end of the day. You will be informed if anything else is needed.

Why are family therapy sessions important?
Family therapy helps improve the overall functioning of the family by addressing needs such as improving communication, strengthening relationships, and increasing each family member's understanding of alternative perspectives/feelings.

What is a discharge plan? One of the most important goals at Clara's House is the development of a plan to establish services and routines that will help your child maintain the progress made during his or her time at Clara's House. Some of these services may include outpatient therapy, psychiatry appointments, case management services, and in-home therapy/skills. Your child's school will also be contacted to help with the creation of a plan for academic success. It is very important that you as a parent establish relationships with these service providers and your child's school because most of the staff at Clara's House can no longer participate in your child's care after discharge.

What are Bridging Therapy Services?
Bridging Therapy provides a unique opportunity for youth and families to meet with a Clara's House therapist before starting the program. Children and adolescents who have recently discharged are also able to meet with a Clara's House therapist for ongoing support if they are unable to see a traditional therapist within a reasonable amount of time.

What is Parent Enrichment?
Parent Enrichment is an education and support group open to any parent/caregiver who has a child at Clara's House. This is an opportunity for parents to feel supported by connecting with other parents who have been through similar experiences. Parents will also learn about effective parenting approaches and increase their understanding of behavioral health.

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What to Expect When You are at Clara's House

We asked patients of all different ages to answer the questions below. We thought it might be best for kids to hear directly from other kids when thinking about what it will be like at Clara's House.

What is Clara's House?
Child: 5 to 9 years old (grades K-4)
"A place to teach kids who have really bad anger."
"A place where I can use my tool bag when I am mad to calm down."

Early Adolescent: 10 to 14 years old (grades 5-8)
"A place that helps you become a better person."
"It is a partial hospitalization program aimed at teaching us coping skills and helping us behave."

Adolescent: 15 to 18 years old (grades 9-12)
"A place to tell your story and learn coping skills where you can feel safe and not be judged."
"A safe place where I can be myself."

What are the program hours of Clara's House?
Monday–Friday, 8:00am–3:00pm during the school year, and 8:00am–2:00pm in the summer.

How long will I be at Clara's House?
Child: 5 to 9 years old (grades K-4)
"4, 5, or 6 weeks."

Early Adolescent: 10 to 14 years old (grades 5-8)
"2, 3, or 4 weeks."
"3-6 weeks."

Adolescent: 15 to 18 years old (grades 9-12)
"About a month."
"Roughly 4 weeks is average."

What will I do at Clara's House?
Child: 5 to 9 years old (grades K-4)
"Learn to have a safe body."
"Learn to control your anger."

Early Adolescent: 10 to 14 years old (grades 5-8)
"Go to various classes to learn coping skills."
"Learn to control anger problems."

Adolescent: 15 to 18 years old (grades 9-12)
"You will have Feelings Group, which is where we talk about our feelings and what's been going on. We also have Skills Group, Recreational Therapy, Art Therapy, and Yoga Therapy. There is also two hours of school during regular school days."
"Learn new ways to express your feelings in a healthy, positive way."

What will I learn from all this?
Child: 5 to 9 years old (grades K-4)
"New coping skills."
"To use coping skills like fidget spinners, putty, and other tools to be calm."

Early Adolescent: 10 to 14 years old (grades 5-8)
"To be kind to others, respectful, and not be aggressive or mean."
"Coping skills and how to be a better person."

Adolescent: 15 to 18 years old (grades 9-12)
"How to turn negative thoughts into positive thoughts and identify your feelings."
"Coping skills, healthy relationships, self-esteem, healthy communication, and identifying emotions."

What is expected of me while at Clara's House?
Child: 5 to 9 years old (grades K-4)
"Be nice."
"Be respectful."

Early Adolescent: 10 to 14 years old (grades 5-8)
"No touching others."
"Use appropriate language."

Adolescent: 15 to 18 years old (grades 9-12)
"Keep boundaries, respect self and others."
"People respect each other here and everyone is welcoming and friendly. We try to be as nice to each other as possible."

How will I get to and from Clara's House?
Child: 5 to 9 years old (grades K-4)
"A van."
"A car or your parents."

Early Adolescent: 10 to 14 years old (grades 5-8)
"A van or car will pick you up."
"By riding the van or being driven by a guardian."

Adolescent: 15 to 18 years old (grades 9-12)
"A van comes to your house and picks you up and if they're at your house and if you almost miss it, they even call you on the phone and that is cool."
"A bus or van will pick you up from your house and take you to Clara's House. It will also pick you up from Clara's House and take you home. The first day you are a little nervous just because you don't know the driver, but after that, it's okay. They're nice."

Why is my Clara's House tool bag or binder important?
Child: 5 to 9 years old (grades K-4)
"Your tool bag has your coping skills in it."
"Your tool bag has things like your coping tools and other toys in it."
Child Unit patients do not use a binder. They receive a tool bag.

Early Adolescent: 10 to 14 years old (grades 5-8)
"The binder keeps all of your stuff organized."
"The Clara's House binder includes many important pieces of information."

Adolescent: 15 to 18 years old (grades 9-12)
"It provides workbooks and sheets for the day, so everything isn't messy. It contains rules, the dress code, and a welcoming paper, very useful."
"It's to transport things to and from home like homework and communication sheets. It has the guidelines and rules, and room for skills packets."

What can I bring to Clara's House?
Child: 5 to 9 years old (grades K-4)
"Sweater, backpack, jacket."
"Show and tell is on Fridays."

Early Adolescent: 10 to 14 years old (grades 5-8)
"You can bring anything, but it will be stored in the office and you will get it back at the end of the day when your transportation is here."
"Your Clara's House binder. You can bring your phone to use on the van, but then you will turn it in to staff when you get to Clara's House and they will store it. You will get it back when your transportation is here at the end of the day."

Adolescent: 15 to 18 years old (grades 9-12)
"Same expectations as school."
"Whatever you bring has to be appropriate, no caffeine, drugs, or weapons."

Why do I have to go to therapy sessions?
Child: 5 to 9 years old (grades K-4)
"Because to see how you are doing here."
"Because they help you."

Early Adolescent: 10 to 14 years old (grades 5-8)
"In individual, family, and group therapy you talk to your therapist by yourself, with family, and with other group members."

Adolescent: 15 to 18 years old (grades 9-12)
"Therapy is good. You have group with your peers to talk. You have an individual session with your therapist to talk about how you're doing. Being honest is best. You have family sessions to talk about family issues."
"You're able to talk to your therapist about anything in individual therapy. Family therapy is where you meet with your parents and therapist to talk about life at home. You also get to have short meetings with a doctor to talk about medications and any other concerns."

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Clara's House
Parental Support Agreement

As the parent of ____________________, I understand that family involvement is critical to my child's success in treatment and overall progress. I agree to fully support my child by fulfilling the following expectations during my child's time at Clara's House:

- Participate in the admission process which lasts two hours or more
- Complete and return the home communication sheet each day and review any attached handouts or forms
- Return phone calls to Clara's House staff as quickly as possible
- Share concerns, ask questions, and inform staff of what might help my child
- Ensure that my child attends programming every day as daily attendance is mandatory
- Participate in family sessions regularly during my child's time at Clara's House
- Share ideas and ask questions about what would help my child be successful at both home and school while knowing that there will likely be recommendations to follow through with after my child graduates from Clara's House
- Support my child's progress at Clara's House by talking with him or her about how things are going and being interested in what he or she is learning about

____
(Parent Signature)

____
(Date)

CentraCare Health

Authorization for Release of Health Information

Please see Directions for additional information on completing.
Please Print

Section	Details
Patient Information	Name: Date of Birth: Address: Phone Number: City: State: Zip Code: Previous Name:
Release Information From	Specific CentraCare Clinic / Hospital or Provider: Address: Phone Number: City: State: Zip Code:
Release Information To	Name of Person, Business, Specific Clinic / Hospital or Provider: Clara's House PHP Address: 1564 County Rd. 134 Phone Number: 320-229-4950 City: St. Cloud State: MN Zip Code: 56303
Information to Be Released Only the information check marked will be released	**Date(s) of service: From: ________ To: ________** **Note: If dates are not specified, only the most recent visit/encounter will be released.** ___ History and Physical ___ Pathology Reports ___ Radiology Reports X Discharge Summary ___ Consult Reports ___ *Radiology Films ___ Emergency Room Notes ___ Laboratory Reports ___ All Records (*not included) X Progress Notes (3-4 recent) ___ Operative/Procedure Notes X Assessment/Evaluation ___ Other (please specify) ________
Special Disclosure	___ Substance Use Disorder Dates of Service: From: ________ To: ________ Concerning: ________ (Specific diagnosis or treatment – do not list ICD-10 codes) *Per Federal Rule 42 CFR Part 2, this section must be completed to release Substance Use Disorder records.*
Preferred Method	___ MyChart (If you do not have MyChart access, please visit www.centracare.com) ___ CD X Paper
Reason for Release	X Continuation or Transfer of Care (to another provider) ___ Personal Use ___ Attorney ___ Insurance ___ Other (specify) ________
Authorization	Patient/Guardian Signature: X Date: X / / Relationship to Patient: X Reason Patient is Unable to Sign: Minor
Revocation	This authorization will expire one year from the date of signature unless I indicate a different date or event here: ________ This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it or upon final disposition of the conditional release for which authorization was given. I may revoke this authorization at any time by notifying, in writing, the provider/facility listed in the FROM section. I understand that such revocation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

CentraCare Health will not refuse treatment to any patient that refuses to sign an authorization for release of Protected Health Information. Once released, the information will no longer be covered under the Federal Privacy Laws. Information not originated by CentraCare Health cannot be released to another facility. I understand that my medical record is part of the CentraCare Health (CCH) Electronic Medical Record. CentraCare Health shares an electronic medical record with non-CCH organizations. Authorizing the release of the following items: Medication List, Allergy List, Problem List, Immunization Data and/or Medical History includes the release of this information from all sites that share an electronic medical record. A list of these non-CCH organizations will be provided to the patient upon request.

Revised 1/18 JEM
CCH_DT0069 M8001555

CentraCare Health

Authorization for Release of Health Information

Please see Directions for additional information on completing.
Please Print

Patient Information	Name	Date of Birth
	Address	Phone Number
	City / State	Zip Code
	Previous Name	
Release Information From	Specific CentraCare Clinic / Hospital or Provider	
	Address	Phone Number
	City / State	Zip Code
Release Information To	Name of Person, Business, Specific Clinic / Hospital or Provider: Clara's House PHP	
	Address: 1564 County Rd. 134	Phone Number: 320-229-4950
	City: St. Cloud / State: MN	Zip Code: 56303
Information to Be Released Only the information check marked will be released	**Date(s) of service: From: ________ To: ________** **Note: If dates are not specified, only the most recent visit/encounter will be released.** ___ History and Physical ___ Pathology Reports ___ Radiology Reports X Discharge Summary ___ Consult Reports ___ *Radiology Films ___ Emergency Room Notes ___ Laboratory Reports ___ All Records (*not included) X Progress Notes (3-4 recent) ___ Operative/Procedure Notes X Assessment/Evaluation ___ Other (please specify) ________	
Special Disclosure	___ Substance Use Disorder Dates of Service: From: ________ To: ________ Concerning: ________ (Specific diagnosis or treatment – do not list ICD-10 codes) *Per Federal Rule 42 CFR Part 2, this section must be completed to release Substance Use Disorder records.*	
Preferred Method	___ MyChart (If you do not have MyChart access, please visit www.centracare.com) ___ CD X Paper	
Reason for Release	X Continuation or Transfer of Care (to another provider) ___ Personal Use ___ Attorney ___ Insurance ___ Other (specify) ________	
Authorization	Patient/Guardian Signature: X	Date: X / /
	Relationship to Patient: X	Reason Patient is Unable to Sign: Minor
Revocation	This authorization will expire one year from the date of signature unless I indicate a different date or event here: ________ This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it or upon final disposition of the conditional release for which authorization was given. I may revoke this authorization at any time by notifying, in writing, the provider/facility listed in the FROM section. I understand that such revocation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.	

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Revised 1/18 JEM
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Behavioral Health Child/Adolescent Intake Form (to be completed by parent/caregiver)

Child Name (First, MI, Last)		**Age**	**Date of Birth**
School		**Grade**	**Today's Date**
Primary MD	**Social Worker**		**County**
Who Referred You?			

What are the current concerns? List in order of importance.

1.____

____

2.____

____

3.____

____

Mental Health Treatment History	**Place(s) and Date(s)**
☐ Psychiatric Consultation	
☐ Outpatient Therapy/Counseling	
☐ Inpatient Hospitalization	
☐ Partial Hospitalization (Hospital-Based)	
☐ Day Treatment (Alternative School or School-Based)	
☐ Chemical Dependency Treatment	
☐ In-Home Family Therapy	
☐ Psychological Testing (IEP, IQ, achievement, etc.)	
Are there other ways that your family has attempted to deal with the concerns?	
1.	
2.	
3.	

SYMPTOM CHECKLIST: Read each item below and decide how much you think your child/adolescent has been showing the problem during the past month. **(0 = Not at all 1 = Rarely 2 = Sometimes 3 = Often)**	
NEURODEVELOPMENTAL SYMPTOMS	
	Fails to give close attention to details or makes careless mistakes in schoolwork, work, or activities
	Has difficulty sustaining attention in tasks or play activities
	Does not seem to be listening when spoken to directly
	Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
	Has a difficult time organizing tasks and activities (e.g. managing sequential tasks, organizing materials, etc.)
	Avoids or dislikes or is reluctant to engage in tasks that require sustained mental effort
	Loses things necessary for tasks or activities
	Is distracted by extraneous stimuli (for adolescents and adults this may include unrelated thoughts)
	Is forgetful in daily activities (e.g., doing chores, running errands, keeping appointments, etc.)
	Fidgets with or taps hands and feet or squirms in seat
	Leaves seat in situations when remaining seated is expected
	Runs about or climbs in situations where it is inappropriate (or feelings of restlessness in adolescents/adults)
	Unable to play or engage in leisure activities quietly
	Is "on the go", acting as if "driven by a motor" (e.g. unable to sit still for extended periods of time)
	Talks excessively
	Blurts out an answer before a question has been completed
	Has difficulty waiting his or her turn
	Interrupts or intrudes on others (e.g. butts into games, conversations or activities, uses others' things)
	Intellectual or cognitive impairment or delays
	Speech or language problems
	Has difficulty in reading (word reading accuracy, reading rate or fluency, reading comprehension)
	Has difficulty in mathematics (number sense, memorization of math facts, accuracy or fluency, reasoning)
	Has difficulty in written expression (spelling, grammar/punctuation, clarity or organization)
	Motor/coordination problems
	Vocal/motor tics (e.g., repetitive eye blinking, throat clearing, facial movements, noises, etc.)
	Has difficulty with social communication and social interaction across multiple contexts/settings. **IF YES, CHECK THOSE BELOW THAT APPLY.**
	☐ Deficits in social-emotional interactions (e.g. approaching others abnormally, failing to converse back and forth, doesn't share interests or feelings, fails to initiate or respond to social interactions, etc.)
	☐ Deficits in nonverbal communication (e.g. abnormal eye contact or body language, lack of facial expression, trouble understanding or using gestures)
	☐ Trouble developing or keeping friendships at a level expected for developmental age
	Restricted, repetitive patterns of behavior, interest, use of objects or speech. **IF YES, CHECK THOSE BELOW THAT APPLY.**
	☐ Repetitive patterns of behavior, interests, use of objects, or speech.
	☐ Repetitive or unusual motor movements, use of objects or speech
	☐ Insistence on things being the same, inflexible routines or patterns of verbal/nonverbal behavior
	☐ Highly restricted interests that are abnormal in intensity or focus
	☐ Under or over-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. indifference to pain/temperature, over response to textures, smells, light, movement, sounds, or tastes)

	DISRUPTIVE BEHAVIOR SYMPTOMS
	Loses temper
	Touchy and easily annoyed
	Angry and resentful
	Argues with adults
	Actively defies or refuses to comply with rules or requests from authority figures
	Deliberately annoys others
	Blames others for own mistakes or misbehavior
	Spiteful or vindictive
	Behavioral outbursts involving verbal or physical aggression
	Bullies, threatens or intimidates other
	Initiates physical fights
	Used a weapon that can cause serious physical harm to others
	Physically cruel to people or animals
	Has stolen while confronting a victim
	Forced someone into sexual activity
	Deliberately engaged in fire setting with the intention of causing damage
	Deliberately destroyed others' property
	Broke into someone's house, building, or car
	Lies in order to obtain favors or to avoid obligations
	Has stolen without confrontation (e.g., forgery, shoplifting)
	Stays out at night without permission
	Has run away from home overnight
	Has been truant
	Verbal aggression or physical aggression toward property, animals, or other individuals, not resulting in physical injury to animals or other individuals.
	Behavioral outbursts involving damage or destruction of property and/or physical assault involving injury against animals or other individuals within a 12-month period.
MOOD SYMPTOMS	
	Temper outbursts manifested verbally and/or behaviorally, that are out of proportion to the situation and are inconsistent with developmental level
	The mood in between temper outbursts is persistently irritable or angry
	Depressed or irritable mood
	Less interest or pleasure in all or almost all activities
	Significant weight loss when not dieting or weight gain (greater than 5% of body weight in a month)
	Difficulty sleeping or oversleeping
	Increased movement and agitation or decreased movement and slowing down
	Fatigue or loss of energy
	Feelings of worthlessness or excessive and inappropriate guilt
	Difficulty thinking or concentrating, or indecisiveness
	Thoughts of death, or suicidal thoughts (with or without a specific plan), or suicide attempt(s)
	Has had a *distinct* period of abnormally and persistently elevated (happy, excited) or irritable mood *and* abnormally and persistently increased goal-directed activity or energy. **IF YES, CHECK THOSE BELOW THAT APPLY.**
	☐ At least 4 days of noticeably increased, inflated self esteem or grandiosity
	☐ At least 4 days of noticeably decreased need for sleep (e.g. feels rested on 3 hours of sleep)
	☐ At least 4 days of noticeably increased talkativeness or pressure to keep talking
	☐ At least 4 days of noticeably increased racing thoughts or flight of ideas
	☐ At least 4 days of noticeably increased distractibility
	☐ At least 4 days of noticeably increased goal-directed activity or motor agitation (purposeless activity)
	☐ At least 4 days of noticeably excessive involvement in high risk activities

ANXIETY SYMPTOMS	
	Fear and anxiety concerning separation from home or major attachment figures
	Failure to speak in certain social situations (e.g., school or with unfamiliar adults) but speaking ok at home
	Marked fear/anxiety about a specific object or situation (e.g., heights, animals, the dark)
	Marked fear/anxiety about social situations involving being observed by others (e.g., performing, conversing)
	Panic attacks (sudden onset of intense fear or physical discomfort that reaches a peak within minutes)
	Anxiety and worry about a number of events or activities, occurring more days than not
OBSESSIVE-COMPULSIVE SYMPTOMS	
	Recurrent and persistent thoughts, urges, or images that cause marked anxiety or distress
	Repetitive behaviors (e.g., hand washing, checking) or mental acts (e.g., praying, counting) that the individual feels driven to perform in response to an obsession or according to rules that must be rigidly applied
	Preoccupation with perceived defects or flaws in physical appearance that are not observable to others
	Difficulty discarding or parting with possessions, regardless of their value (i.e., hoarding)
	Hair pulling
	Skin picking
TRAUMA- AND STRESSOR- RELATED SYMPTOMS	
	Has experienced a pattern of extreme, insufficient care (e.g., neglect, deprivation, changes in caregivers, etc.) **IF YES, CHECK THOSE THAT APPLY**
	☐Rarely or minimally seeks or responds to comfort from caregivers when upset or distressed
	☐Minimal social and emotional responsiveness to others
	☐Limited positive emotions
	☐Episodes of unexplained irritability, sadness or fearfulness during interactions with adult caregivers
	☐Reduced caution in approaching and interacting with unfamiliar adults
	☐A pattern of actively approaching and interacting with unfamiliar adults (e.g., a willingness to go off with unfamiliar adults with little or no hesitation, being overly familiar, not checking back with caregivers after venturing away, etc.)
	Has had exposure to actual or threatened death, serious injury, or sexual violence **IF YES, CHECK THOSE THAT APPLY**
	☐Recurrent, distressing memories or dreams of the traumatic event
	☐Re-enactment of the traumatic event in repetitive play activities
	☐Intense, physical or emotional distress when exposed to reminders of the traumatic event
	☐Flashbacks of the traumatic event (i.e., feeling or acting as if the traumatic events were recurring)
	☐Persistent avoidance of memories, thoughts, feelings, places or objects associated with the traumatic event
	☐Negative changes in thoughts or mood beginning or worsening after the traumatic event (e.g., guilt, shame, loss of interest, feeling detached, self-blame, etc)
	☐Marked changes in arousal or reactivity, beginning or worsening after the traumatic event (e.g. angry outbursts, hypervigilance, problems sleeping, reckless/destructive behavior, etc.)
DISTORTED THINKING OR PERCEPTION SYMPTOMS	
	Delusions (i.e., persistent odd or false beliefs)
	Hallucinations (i.e., hearing or seeing things that are not really there)
DISORDERED EATING SYMPTOMS	
	Episodes of binge eating
	Inappropriate behaviors used to prevent weight gain (e.g., self-induced vomiting, misuse of laxatives or diuretics, fasting, excessive exercise, etc.)
	Restriction of food intake leading to significantly low body weight (i.e., less than minimally expected)
	Fear of gaining weight or becoming fat
	Disturbance in the way in which one's body weight or shape is experienced

GENDER DYSPHORIA SYMPTOMS	
	Incongruence between one's experienced/expressed gender and actual gender, of at least 6 months duration

MISCELLANEOUS SYMPTOMS
Are there other symptoms or concerns that you have about this child/adolescent?

Risk Indicators (Check all that apply)	
	Wish to be Dead: has had thoughts about a wish to be dead or not live anymore, or a wish to fall asleep and not wake up.
	Suicidal Thoughts: has had non-specific thoughts of wanting to end life/die by suicide.
	Suicide Behavior: has had an actual suicide attempt, an interrupted attempt, or other preparatory acts to kills self
	Self-injurious behavior ***without*** suicidal intent
	Method for suicide available (gun, pills, etc.)
	☐No firearms in the home ☐Firearms are easily accessed ☐Use of safe firearm and ammunition storage practices
	Family history of suicide (lifetime)
	Recent loss(es) or other significant negative event(s) (legal, financial, relationship, etc.)
	Arrests/Pending incarceration
	Current or pending isolation or feeling alone
	Hopelessness
	Command hallucinations to hurt self
	Highly impulsive behavior
	Drug or alcohol abuse/dependence
	Perceived burden on family or others
	Chronic physical pain or other acute medical problem
	Homicidal thoughts/preoccupation with violence
	Aggressive behavior toward others
	Sexual abuse (lifetime)
	Unhealthy peer group
	Inappropriate sexual activity

Current Living Situation		
Parent's name:	Age:	☐Biological ☐Adoptive ☐ Step
Address:	City:	State:
Lives with the child/adolescent? ☐Yes ☐No	If not, where does he/she live?	
Employed outside of the home? ☐Yes ☐No	Occupation:	Hours/wk:
Parents's name:	Age:	☐Biological ☐Adoptive ☐ Step
Address:	City:	State:
Lives with the child/adolescent? ☐Yes ☐No	If not, where does he/she live?	
Employed outside of the home? ☐Yes ☐No	Occupation:	Hours/wk:
Parents' marital status: ☐never married. ☐married for _____ years. ☐separated. ☐divorced.		
If parents are divorced, describe physical and legal custody?		
Other parent(s) or caregiver(s) names (*if different from above*):		
Relationship to patient:		
Relationship to patient:		
Is the caregiver employed outside the home? ☐Yes ☐No	Occupation:	Hours/wk:

Legal guardian of patient, if other than biological parent(s):

List all people this child/adolescent is presently living with:

Name	Age	Relation	Health Status:
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor
			Good/Fair/Poor

List any immediate family members who do not live with this child/adolescent and any deceased family members:

Name	Living	Age	Relation	City, State
	Y/N			
	Y/N			
	Y/N			
	Y/N			
	Y/N			
	Y/N			

Developmental History

Prenatal and Delivery History

How was the mother's overall health during pregnancy with this patient?: ☐good ☐fair ☐poor ☐don't know

How was the mother's overall health during pregnancy with this patient?: ☐good ☐fair ☐poor ☐don't know

Did the mother experience any medical problems or complications during pregnancy? ☐Yes ☐No
If yes, please specify:

How old **were** the parents when this patient was born? Mother _______ Father _______

What substances, if any, did the mother use during the course of the pregnancy (including before learning that she was pregnant)?
☐Alcohol: Describe amount and frequency. ______________________________
☐Tobacco: Describe amount and frequency. ______________________________
☐Street Drugs: Describe what drugs, amount and frequency. ______________________________
____
☐Prescription Drugs: Describe what drugs, amount and frequency. ______________________________
____

Was this child/adolescent born: ☐less than 30 weeks gestation ☐30-35 weeks ☐36-40 weeks ☐over 40 weeks

Was delivery: ☐Normal ☐Breech ☐Caesarian ☐Forceps/vacuum assisted ☐Induced

What was the child/adolescent's birth weight? _________

Were there indications of fetal distress during labor/birth? ☐Yes ☐No
If yes, please specify ______________________________

Were there any health complications following birth? ☐Yes ☐No
If yes, please specify ____

Postnatal Period and Infancy

Were there any infancy feeding problems? ☐Yes ☐No
If yes, please specify ____

Was this child/adolescent colicky as an infant? ☐Yes ☐No
If yes, please specify ____

Were there infancy sleep pattern difficulties? ☐Yes ☐No
If yes, please specify ____

Were there problems with responsiveness/alertness during infancy? ☐Yes ☐No
If yes, please specify ____

How easy was this child/adolescent as a baby?
☐Very easy ☐Easy ☐Average ☐Difficult ☐Very Difficult

Were there any concerns about this child/adolescent's attachment to the primary caregiver(s)? ☐Yes ☐No
If Yes, please specify ____

Toddler Period

As an infant/toddler, how did this child/adolescent behave with other people?
☐More sociable than average ☐Average sociability ☐Actively avoided socializing ☐Shyer than average

As an infant/toddler, how insistent was this child/adolescent when he or she wanted something ?
☐Very insistent ☐Somewhat insistent ☐Average ☐Passive

As an infant/toddler, how active was this child/adolescent?
☐Very active ☐Active ☐Average ☐Less active ☐Very inactive

How would you describe this child's play as an infant/toddler? (Check all that apply)
☐Loud ☐Interested in playing with others ☐Imaginative / Make believe
☐Quiet ☐Played alone ☐Repetitive ☐Rigid, concrete

Developmental Milestones

Have you or anyone else ever had concerns about this child/adolescent's development? ☐Yes ☐No
If yes, please specify ____

At what age (in months) did this child/adolescent:
Sit up? __________ Crawl? __________ Walk? __________

At what age (in months) did this child/adolescent speak single words (other than "Mama" or "Dada")? __________

At what age (in months) did this child/adolescent begin stringing two or more words together? __________

At what age (in months) was this child toilet trained? For bladder _________ For bowel __________

Medical History

How would you describe your child/adolescent's health?
☐Very Good ☐Good ☐Fair ☐Poor ☐Very Poor

How is his/her hearing? ☐Good ☐Fair ☐Poor
Vision? ☐Good ☐Fair ☐Poor
Speech and language? ☐Good ☐Fair ☐Poor
Fine motor coordination? ☐Good ☐Fair ☐Poor
Gross motor coordination? ☐Good ☐Fair ☐Poor

Has this child/adolescent ever had chronic health problems (e.g., asthma, diabetes, allergies, heart condition)? ☐Yes ☐No
If yes, please specify ______________________________

Which of the following illnesses has this child/adolescent had? Check all that apply:
☐Chronic diarrhea ☐Stomach aches ☐High fevers ☐Chronic pain ☐Chronic ear infections
☐Constipation ☐Allergies ☐Encephalitis ☐Chronic headaches ☐Lead poisoning
☐Asthma ☐Croup ☐RSV ☐Chicken pox ☐Urinary tract infections
☐Pneumonia ☐Seizures ☐Meningitis ☐Other ______________________

Did this child/adolescent experience any medical problems aside from the usual childhood illnesses? ☐Yes ☐No
If yes, please specify ______________________________

Has this child/adolescent ever been hospitalized? ☐Yes ☐No
If yes, please specify the reason, date, outcome and name of hospital. ______________________________
____
____

Has this child/adolescent ever been brought to the emergency room for emotional or behavioral problems? ☐Yes ☐No
If yes, please specify the reason, date, outcome and name of hospital. ______________________________
____
____

Has this child/adolescent ever received medication for emotional, physical, learning or behavioral problems? ☐Yes ☐No
If yes, please specify:

Medication #1: ______________________
Reason prescribed? ______________________
Daily Dose: ______________________
Who Prescribed This?: ______________________
How long was this taken?: ______________________
Was this helpful? ______________________
Side effects: ______________________

Medication #2: ______________________
Reason prescribed? ______________________
Daily Dose: ______________________
Who Prescribed This? ______________________
How long was this taken? ______________________
Was this helpful? ______________________
Side effects: ______________________

Medication #3: ______________________
Reason prescribed? ______________________
Daily Dose: ______________________
Who Prescribed This? ______________________
How long was this taken? ______________________
Was this helpful? ______________________
Side effects: ______________________

Medication #4: ______________________
Reason prescribed? ______________________
Daily Dose: ______________________
Who Prescribed This? ______________________
How long was this taken? ______________________
Was this helpful? ______________________
Side effects: ______________________

Medication #5: ______________________________________
Reason prescribed? __________________________________
Daily Dose: ____
Who Prescribed This? _________________________________
How long was this taken? ______________________________
Was this helpful? ____________________________________

Side effects: ____

Medication #6: ____________________________________
Reason prescribed? ___________________________________
Daily Dose: ____
Who Prescribed This? _________________________________
How long was this taken? ______________________________
Was this helpful? ____________________________________

Side effects: ____

Has this child/adolescent ever experienced any accidents resulting in the following? (Check all that apply)

☐Sutures ☐Broken bones ☐Severe lacerations ☐Head injury
☐Severe bruises ☐Loss of teeth ☐Loss of consciousness ☐Eye injury

Please explain the injury: ____

Does this child/adolescent have any bladder control problems?: ☐No ☐Yes
If yes, are these … ☐During the day? ☐During the night?

Does this child/adolescent have any bowel control problems?: ☐No ☐Yes
If yes, are these … ☐During the day? ☐During the night?

This child/adolescent's usual bedtime is at: _______________ when in school. _______________ when on vacation.

Describe this child/adolescent's sleep patterns or habits:

☐Sleeps all night without disturbance ☐Has trouble falling asleep ☐TV in bedroom ☐Early morning awakening
☐Awakens during night/restless sleeper ☐ Screen time up to bedtime ☐Severe snoring ☐Sleeps outside bedroom
☐ Gets out of bed in middle of the night ☐ Sleeps with parent(s)

Describe this child/adolescent's eating habits:

☐Overeats ☐Average ☐Under eats ☐Binge eating ☐Intentionally restricts intake

Family Health History

	Mother	Father	Sibling	Describe the disability or health problem
Family member disability?				
Family member serious health problems?				

Family Mental Health History

Check all that apply to biological family	Mother	Maternal family	Father	Paternal family	Siblings
Heart Problems					
Thyroid Problems					
Problems with inattention, hyperactivity/ impulse control.					
Problems with aggression, oppositional, or antisocial behavior as a child.					
Learning disabilities					
Cognitive/intellectual disabilities					
Autism Spectrum					
Anxiety					
Depression					
Obsessive Compulsive Disorder					
Eating Disorder					
Schizophrenia or Psychosis					
Bipolar Disorder					
Suicidal thoughts or attempts					
Drug abuse or dependence					
Victim of sexual abuse					
Victim of physical abuse					
Other: (specify)					

Cultural/Spiritual Influences

Describe any important spiritual/religious/cultural influences that are important in understanding this child/adolescent's problems or treatment: ____

____

Life Stressors/Trauma History

Has this child/adolescent experienced or witnessed any of the following? (Check all that apply)

☐ Domestic violence/abuse: Explain ____

☐ Community violence: Explain ____

☐ Physical abuse: Explain ____

☐ Verbal or Emotional abuse: Explain ____

☐ Sexual assault/molestation: Explain ____

☐ Physical neglect: Explain ______________________________

☐ Serious illness: Explain ______________________________

☐ Serious accident : Explain ______________________________

☐ Divorce/Separation/Remarriage of Parent: Explain ______________________________

☐ Change of residence: Explain ______________________________

☐ Change of schools: Explain ______________________________

☐ Job changes of parents: Explain ______________________________

☐ Pregnancy/Miscarriage/Abortion: Explain ______________________________

☐ Family chemical abuse: Explain ______________________________

☐ Exposure to drug activity (outside of the home): Explain ______________________________

☐ Foster care or other type of out-of-home placement: Explain______________________________

☐ Arrests/Imprisonments in family: Explain ______________________________

☐ Death/loss of family member: Explain ______________________________

☐ Death/loss of friend: Explain ______________________________

☐ Family accident or illness: Explain ______________________________

☐ Financial changes or stressors: Explain ______________________________

☐ Parent conflicts in disciplining: Explain ______________________________

☐ Other: Explain ______________________________

Strengths and Quality of Social Network

What are this child/adolescent's strengths?

1. ______________________________
3. ______________________________
2. ______________________________
4. ______________________________

What does this child/adolescent like to do?

Activities: ______________________________

Hobbies: ______________________________

Describe this child/adolescent's relationship with each parent:

Mother: ______________________________

Father: ______________________________

Step mother: ______________________________

Step father: ______________________________

Other caregivers: ______________________________

____

Describe this child/adolescent's relationship with siblings:

____

____

Describe this child/adolescent's relationship with peers:

____

____

Describe the parent relationship and any impact on this child/adolescent:

Educational History

Does your child/adolescent have an IEP for special education services?: ☐No ☐Yes

If no, has your child ever been tested and determined not to need services? ☐No ☐Yes

Please summarize your child/adolescent's academic, behavioral and emotional progress within each of these grade levels. Please include any teacher observations.

Grade	Progress	School/Program
Preschool/ Daycare		
Kindergarten		
1st grade		
2nd grade		
3rd grade		
4th grade		
5th grade		
6th grade		
7th grade		
8th grade		
9th grade		
10th grade		
11th grade		
12th grade		

Has this child/adolescent repeated any grades? ☐Yes ☐No

If yes, please specify which grade and why: ____

____

Has this child/adolescent participated in any special education or other programming? If so, indicate which grade(s).

Program	Grade(s)	Program	Grade(s)
Early Childhood Spec. Ed./Developmental Delay	________	Developmental/Cognitive Disability	__________
Special Learning Disability	____________	Autism Spectrum Disorder	___________

What are this child/adolescent's strengths in school? ____

What are this child/adolescent's weaknesses in school? ____

Is the school doing a good job of meeting your child/adolescent's needs? ____

Is your child/adolescent currently employed? If yes, where and how many hours/week? ____

Alcohol / Substance Use

Does your child or adolescent drink alcohol? ☐Yes ☐No

Has your child or adolescent ever experimented with drugs? ☐Yes ☐No

If you responded "no" to both questions, you can STOP here. Thank you for providing us with this important information.

If you responded "yes" to one or both questions, please complete the remaining questions:

CAGE-AID Questions (to be completed by a child/adolescent age 12 and up)

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?
4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

Which category of mood-altering substances has your child/adolescent used?

☐Alcohol ☐Prescription drugs ☐Street drugs ☐Over-the-counter drugs ☐None known

Please name all mood-altering substances this child/adolescent has used:

How many years altogether has this child /adolescent been drinking and/or using drugs? ________________________________

How would you describe this child/adolescent's pattern of alcohol or chemical use"?

☐Continuous and progressive ☐On and off with no pattern ☐A fairly regular pattern ☐Decreasing but more destructive

Has this child/adolescent shown signs of significant mood changes? ☐Yes ☐No

If yes, please explain:

The following is a list of common symptoms in individuals who are abusing alcohol or drugs. Please check all that apply.

☐Blackouts. How often: ____

☐Minimizes the extent of their use. Describe: ____

☐Lies about where they go or who they are with. When did this start? ______________________________

☐Engages in abusive or aggressive behavior. Describe: ____

☐Uses mood altering drugs/medications when drinking or substitutes medications for alcohol?

☐Stops drinking for periods of time. How often and why? ____

☐There have been changes in this child/adolescent's drinking pattern. Describe: ________________________

____

☐This child/adolescent's drinking and/or chemical use has resulted in changes in family activities. Describe: ____________

____

☐Unreasonable resentments. Describe: ____

____

☐ Changes in sexual drive or activity. Describe: ______

☐ Binges or benders. Describe: ______

☐ Tremors or alcohol/drug related physical problems. Describe: ______

☐ Narrowed range or lack of interests. Describe: ______

☐ Changes in the type of friends or attitudes toward friends. Describe: ______

☐ Left or threatened to leave home after being confronted about chemical use. Describe: ______

☐ Was told by a physician that chemical use is injuring his/her health. Describe: ______

☐ Family members have complained that this child/adolescent spends too much money on alcohol or other chemicals. Describe: ______

☐ Has quit or been threatened with expulsion or suspension from school due to chemical use. Describe: ______

☐ Has been picked up/arrested by police for intoxication or other chemical use related charges. Describe: ______

☐ Has had accidents/injuries related to drinking or chemical use. When/Describe: ______

☐ Has had illnesses related to drinking or chemical use. When/Describe: ______

☐ Has been gone from home without notifying parent(s). When/Describe: ______

☐ Has had other negative consequences related to drinking or substance use. Describe: ______

We/I feel responsible for this child/adolescent's drinking/chemical use? ☐ Yes ☐ No

We/I sometimes feel guilty about this child/adolescent's drinking/chemical use? ☐ Yes ☐ No

We/I feel this child/adolescent could quit drinking/using if he/she wanted to badly enough? ☐ Yes ☐ No

This child/adolescent simply lacks the will power to quit drinking/using? ☐ Yes ☐ No

Alcoholism is not a disease so much as it is a sin and moral problem? ☐ Yes ☐ No

We/I feel that this child/adolescent isn't alcoholic or chemically dependent but rather has a drinking/use problem? ☐ Yes ☐ No