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| **Student Information** |
| **Name****Date of Birth:****Biological Sex:****Gender Identity:****Date Placement Needed:** |  |  **Record #:**  |
|  |  **Race:** |
|  **Male**  **Female** |
|  **Male**  **Female** **Transgender/Non-Binary**  |  **SSN:**  |
|  |
| **Legal Custodian: Name, Address, Phone, Email** |  |
| **Parent:****Name, Address, Phone, Email** |  |
| **Current Living Arrangement:** |  |
| **MCO:** **Care Coordinator Info:** | Name: |
| Phone number: |
| Email address: |
| Mailing Address: |
| **Case Responsible Agency:**  | Case Responsible Professional (required): |
| Email Address: |
| Address: |
| Office Number/Cell/ Fax Number: |
| Case Responsible Professional (required): |
| **Current Mental Health Team:** | Therapist Name: |
| Therapist Phone Number: |
| Therapist Email Address: |
| Psychiatrist Name: |
| Psychiatrist Phone Number: |
| Psychiatrist Email Address: |

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| **CURRENT STATUS** |
| **I. CURRENT BEHAVIORS/PRESENTING PROBLEMS AND REASON FOR REFERRAL** |
|  \_ \_ |
| **Assessment** **Information** | **Has the student ever received a psychological assessment?**  **Yes**  **No If Yes, date:** **Is consideration for a psychological assessment being requested?** **Yes**  **No** **If yes, complete below:****Primary/specific question(s) to be addressed through this assessment:** **Services requested:** **Diagnostic Clarification:**  **Autism**  **Depression**  **Bipolar**  **Anxiety**  **Disruptive Behaviors** **Cognitive functioning (IQ/processing)**  **Adaptive skills evaluation** **Academic assessment**  **Social/emotional assessment****Name of guardian or family member who will complete rating scales/interview questions: Contact information: (if different than guardian)** |
| **Diagnoses/ Diagnosticians:** | **Diagnosis** | **Diagnostician** | **Date** |
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| **Medications:****Prescriber:** **\_****Primary Care Physician:** | **Medication: List all current medications** | **Dose** | **Frequency** |
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| **II. CURRENT STRESSORS** (Please check those that apply and describe in related sections) |
| Legal Problems | □ Yes | □ No | Physical Assault | □ Yes | □ No | Addiction | □ Yes | □ No |
| Medical Problems | □ Yes | □ No | Relationship Problems | □ Yes | □ No | Abuse History | □ Yes | □ No |
| Sexual Assault/ Rape | □ Yes | □ No | Separation/Loss | □ Yes | □ No | Other | □ Yes | □ No |

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| **III. HEALTH CONCERNS and MEDICAL CONDITIONS** |
|  | Please describe the nature of the disorder or disease, as well as necessary treatment: |
| **A. Physical disorders or diseases:** |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contagious Disease? |
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| **B. Disabilities:**(senses, physical, other) | Please describe the nature of the disability and any necessary accommodations: |
|  | Please provide any history of seizure disorder, head injury, or other traumatic injury sustained by the student.Are there any on-going medical concerns or treatments related to these events?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **C. History of Seizures,** |
| **Head Injury, or Other** |
| **Traumatic Injury:** |
|  |
| **IV. ABUSE HISTORY** |
| Has the client been a victim of abuse?  Yes  No If yes,  Physical  Sexual  Emotional Has the client been a victim of neglect?  Yes  NoHow old was the client? Was this reported to DSS? What was the legal outcome? Please describe the nature of the abuse/ neglect, including the perpetrator, duration of abuse/ neglect, etc.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **V. HISTORY OF AGGRESSIVE BEHAVIOR** |
| 1. **Please describe the nature of the student’s acting out behaviors:**
	* Verbally aggressive Frequency: Description:
	* Physically aggressive Frequency: Description: \_
	* Has this behaviors resulted in injury to others? Criminal Charges? Please describe?
	* Property destruction: Frequency: Description:
	* Cruelty to animals Frequency: Description: \_
	* Fire Setting Frequency: Description:

**Aggression is**:  impulsive  planned  instrumental  triggered by fearfulness1. **Where is the client aggressive**:
2. **Known triggers, please describe**:
3. **Main targets of aggression:** □ Peers □ Authority figures □ Family members Please be specific:
4. **Please describe the most recent episode of aggression:**

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| **VI. HISTORY OF SELF INJURIOUS AND SUICIDAL BEHAVIORS** (Check all options that apply) |
| **Self-Injury:** |  Cuts on body |  Conceals cutting surfaces |
| Preferred cutting surfaces: Preferred Cutting Implement: |
|  Other forms of self-injury (please describe) Has self-injury ever required medical attention? Explain. \_ |
| **Suicidal Characteristics:** | Check all that apply: |  Suicidal Ideas |  Suicidal Gestures |  Suicidal Plans |
|  Suicide Attempts |  Number of previous attempts:  |
|  Describe: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Methods used in previous attempts (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Were attempts planned?  Yes  No  Sometimes |
| Does the client know someone who has committed suicide (describe relationship to child): \_ |

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| **VII. History of Running** |  Runs away from home or placementsIn the past year, how many times has the student run? Impulsive or planned? Average duration of run: \_ Where does the student go and what do they do? How do they return home/placement? \_ |
| **VIII. Substance Abuse History** | **Type of Substance used** | **Frequency** | **Last Use** | **Type of Substance used** | **Frequency** | **Last Use** |
|  Marijuana |  |  |  Inhalants |  |  |
|  Cocaine |  |  |  Hallucinogens |  |  |
|  Crack |  |  |  Alcohol |  |  |
|  Heroin/ Opiates |  |  |  Tranquilizers |  |  |
|  Amphetamines |  |  |  Other  |  |  |
| Has the client received Substance Abuse treatment? \_ |
|  | Please describe any sexualized behaviors exhibited by the student (i.e. exposure, sexual acting out, predatory behaviors, |
| **IX. Sexualized****Behaviors** | etc.): \_ |
|  |  \_ |
|  |  \_ |
| **X. Psychotic** **Behaviors** | **Has the client experienced any hallucinations or paranoid ideation:**  **Y**  **N If yes, what type?** **Auditory**  **Visual**  **Other****Please describe the nature of the hallucinations and/or paranoia, including the frequency and treatment provided.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **I. PLACEMENT HISTORY:** |
|  | Name of Hospital | Reason for Hospitalization | Reason for Discharge | AdmissionDate (mm/dd/yy) | DischargeDate (mm/dd/yy) |
| List all hospitalizations |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |
|  | Placement Name/ Level of Care | Reason for Placement | Reason for Discharge | AdmissionDate (mm/dd/yy) | DischargeDate (mm/dd/yy) |
| List all prior out of home placements. |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  | Name of Provider | Service Type | Reason for Referral | Admission Date(mm/dd/yy) | Discharge Date(mm/dd/yy) |
| List all prior or current mental health services. |  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |
| **II. EDUCATIONAL INFORMATION** |
| **A. School information** | Last School Attended: School district/LEA: Grade Level: History of Truancy:  Y  NIn past year has skipped school…  1-5 days  6-10 days  11-15 days  more than 15 days |
| Please describe any additional academic-related information of which we should be aware (i.e. suspensions, expulsions, IEP, etc.): |
|  | Special Ed?  Y  N IEP:  BED  EMD  SLD  OHI  504 Plan  Other:  |
|  | Date IEP/504 Plan expires \_ |
| **B. IQ Information** | Current IQ Score (**Required**): FSIQ- VCI- PRI- WMI- \_ PSI-  |
|  | Test Administered: \_ |
|  | Date Administered: \_ |

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| **III. LEGAL INVOLVEMENT** |
|  | **Charge:** Attach any applicable court documents or description of events | **Date** | **Outcome** |
| **A. Charges:** List all past, current, and pending charges. |  |  |  |
| **B. Probation** | Is the student currently on probation?  Yes  NoIf yes, please describe the length and all applicable terms: \_ |

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| **RELEVANT HISTORY** |
| **IV. SOCIAL HISTORY/ FAMILY DYNAMICS:** |
| Please provide a brief description of the student’s social history. Include information on family dynamics, family mental health history, and any significant events leading up to the student’s involvement in mental health treatments:* *Please provide the most recent* ***Comprehensive Clinical Assessment*** *and/or* ***Psychological Evaluation****.*

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| **VI. STRENGTHS & INTERESTS** |
| Please describe the strengths and interests of the client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **XII. FUNDING: *\* Include copies (front and back) of all insurance cards applicable to the student.*** |
| **Please check all applicable funding sources available for the student. Include all applicable numbers (subscriber, group, etc.) associated with each funding source. For private insurance, include the SSN and DOB of policy holder.*** Medicaid:  Health Choice: \_
* Private Insurance: \_ Policy Number: \_

Subscriber/ Group #: Policy Holder Name: Policy Holder SSN: Policy Holder DOB: *(Attach all applicable information on any additional private insurance associated with the student.)* |

I hereby apply for services on behalf of the child for whom I hold legal custody and/or placement authority. I certify that the information contained in this application/assessment is true and accurate to the best of my knowledge.

Custodian Signature Date

Referring Professional/ Agency Date