



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 :

<input type="checkbox"/> Sad or unhappy most of the time <input type="checkbox"/> Cries a great deal <input type="checkbox"/> Decreased energy <input type="checkbox"/> Feelings of being worthless/helpless <input type="checkbox"/> Apathy—doesn't seem to care <input type="checkbox"/> Frequently negative thinking <input type="checkbox"/> Loss of interests-doesn't enjoy things <input type="checkbox"/> Thoughts of suicide or self-harm <input type="checkbox"/> Angry/easily irritated	<input type="checkbox"/> Temper tantrums <input type="checkbox"/> Frequently Lies <input type="checkbox"/> Frequently Swears <input type="checkbox"/> Talks back to adults <input type="checkbox"/> Is aggressive/confrontational to adults <input type="checkbox"/> Rarely follows instructions <input type="checkbox"/> Can't be trusted <input type="checkbox"/> Unmotivated <input type="checkbox"/> Runs away from home	<input type="checkbox"/> Bites nails/pulls own hair <input type="checkbox"/> Lots of aches and pains <input type="checkbox"/> Difficulty sleeping (e.g.: can't fall asleep, nightmares, sleep walks) <input type="checkbox"/> Does not get enough sleep (stays up late) <input type="checkbox"/> Self-mutilates <input type="checkbox"/> Body image difficulties <input type="checkbox"/> Substantial recent change in weight or appetite
<input type="checkbox"/> Afraid of many things <input type="checkbox"/> Very shy <input type="checkbox"/> Panic attacks <input type="checkbox"/> Avoids going places/being with others <input type="checkbox"/> Checks things repeatedly <input type="checkbox"/> Needs things to be perfect <input type="checkbox"/> Sensitive to criticism <input type="checkbox"/> Excessive or senseless worries <input type="checkbox"/> Lacks confidence in abilities <input type="checkbox"/> Dependent/needs a lot of reassurance	<input type="checkbox"/> Picks on other children <input type="checkbox"/> Tries to boss others around <input type="checkbox"/> Has few or no friends <input type="checkbox"/> Is seen as weird or different by peers <input type="checkbox"/> Isolates self away from others <input type="checkbox"/> Poor loser <input type="checkbox"/> Afraid of rejection <input type="checkbox"/> Doesn't trust other people <input type="checkbox"/> Victim of bullies <input type="checkbox"/> Physical fights with other children	<input type="checkbox"/> Exhibits inappropriate sexual behavior <input type="checkbox"/> Trouble with knowing what is real <input type="checkbox"/> Demonstrates bizarre behavior (e.g.: hearing voices/seeing things) <input type="checkbox"/> Rapid mood changes without cause <input type="checkbox"/> Extreme risk taking or impulsivity <input type="checkbox"/> Recurrent intrusive thoughts <input type="checkbox"/> Cruel to animals <input type="checkbox"/> Immature <input type="checkbox"/> Dating problems
<input type="checkbox"/> Concentration difficulties <input type="checkbox"/> Daydreams <input type="checkbox"/> Needs lots of reminders <input type="checkbox"/> Doesn't finish things <input type="checkbox"/> Can't sit still/very active <input type="checkbox"/> Acts without thinking <input type="checkbox"/> Easily distracted <input type="checkbox"/> Demands too much attention	<input type="checkbox"/> Has problems learning in school <input type="checkbox"/> Hates going to school <input type="checkbox"/> Seems afraid of going to school <input type="checkbox"/> Difficulty following school rules <input type="checkbox"/> Often skips school <input type="checkbox"/> Has conflicts with teachers <input type="checkbox"/> Performs below his/her ability <input type="checkbox"/> Problems with homework	<input type="checkbox"/> Concerns with alcohol <input type="checkbox"/> Concerns with drug use <input type="checkbox"/> Has been in trouble with the law <input type="checkbox"/> Has had problems with pornography <input type="checkbox"/> Steals <input type="checkbox"/> Breaks things <input type="checkbox"/> Has used a weapon <input type="checkbox"/> 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)? _____

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 RELATIONSHIPSAre parents divorced or separated? No Yes

If yes, how long? _____

What are the current custody/visitation arrangements? _____

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

Name	Age	Relationship (e.g. Father, Mother, Brother, Sister, Step-Sibling, Aunt, Uncle)	Quality of Relationship	Living with you?
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

If so, please describe your concerns _____

YOUR CHILD'S BIRTH AND EARLY DEVELOPMENT

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

Were there any complications with the pregnancy of this child that might have impacted his/her prenatal health or development? (e.g.: mother had significant illness, smoked cigarettes, drank alcohol, experienced severe bleeding, etc.)

No Yes

Were there significant problems with this child's health or development in the first few years of his/her life? (e.g.: needed to be revived at birth, failure to thrive, missed significant developmental milestones)

No Yes

If yes, please explain: _____

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

YOUR CHILD'S LIFE STORY

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

EDUCATIONAL HISTORY:

Where does your child attend school? _____

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

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

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

Has your child experienced any of the following in school? Learning Problems Discipline Problems
 Social Problems Emotional Problems

Has there been any academic or psychological testing done at school or elsewhere? No Yes

If yes, when? _____

Results: _____

PREVIOUS COUNSELING TREATMENT HISTORY:

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

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

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

ABUSE HISTORY

Has your child ever been the victim of abuse or neglect?

 No YesIf yes, was the abuse: Physical Sexual Emotional Neglect Verbal

Has your child ever been the perpetrator of abuse?

 No YesIf 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)

Name of Medication	Dosage/Amount	Frequency

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: _____ Date: _____

(Please sign your name)

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) _____
- Pamelor (Nortriptyline) _____
- Parnate (Tranylcypromine) _____
- Paxil, (Paroxetine) _____
- Pristiq (Desvenlafaxine) _____
- Prozac; Sarafem (Fluoxetine) _____
- Remeron, (Mirtazapine) _____
- Serzone (Nefazodone) _____
- Sinequan (Doxepin) _____
- Surmontil (Trimipramine) _____
- Tofranil (Imipramine) _____
- Vivactil (Protriptyline) _____
- Wellbutrin, (Bupropion)/Zyban _____
- Zoloft (Sertraline) _____

ANTI-ANXIETY and INSOMNIA MEDICATIONS

- Ambien, (Zolpidem) _____
- Ativan (Lorazepam) _____
- Benadryl (Diphenhydramine) _____
- BuSpar (Buspirone) _____
- Dalmane (Flurazepam) _____
- Halcion (Triazolam) _____
- Klonopin (Clonazepam) _____
- Librium (Chlordiazepoxide) _____
- Lunesta (Eszopiclone) _____
- Noctec (Chloral hydrate) _____
- ProSom (Estazolam) _____
- Restoril (Temazepam) _____
- Rozerem (Ramelteon) _____
- Serax (Oxazepam) _____
- Sonata (Zaleplon) _____
- Tranxene (Clorazepate) _____
- Unisom (Doxylamine) _____
- Valium (Diazepam) _____
- Vistaril, Atarax (Hydroxyzine) _____
- Xanax (Alprazolam) _____

OTHER MEDICATIONS NOT LISTED ABOVE

STIMULANT MEDICATIONS

- Adderall _____
- Concerta, Daytrana TD Patch, Metadate, Ritalin (Methylphenidate) _____
- Dexedrine (Dextroamphetamine) _____
- Focalin (Dexmethylphenidate) _____
- Provigil _____
- Strattera (Atomoxetine) _____
- Tenex (Guanfacine) _____
- Vyvanse (Lisdexamfetamine) _____

MEDICATIONS FOR SIDE EFFECTS

- Artane (Trihexyphenidyl) _____
- Benadryl (Diphenhydramine) _____
- Cogentin (Benztropine) _____
- Inderal (Propranolol) _____
- Parlodel (Bromocriptine) _____

MOOD STABILIZERS

- Carbatrol, Equetro, Tegretol (Carbamazepine) _____
- Depakote, (Divalproic Acid) _____
- Eskalith, Lithobid (Lithium) _____
- Lamictal (Lamotrigine) _____
- Topamax (Topiramate) _____
- Trileptal (Oxcarbazepine) _____

ANTIPSYCHOTICS

- Abilify, (Aripiprazole) _____
- Clozaril, Fazacllo (Clozapine) _____
- Geodon, (Ziprasidone) _____
- Haldol (Haloperidol) _____
- Invega (Paliperidone) _____
- Loxitane (Loxapine) _____
- Mellaril (Thioridazine) _____
- Moban (Molindone) _____
- Navane (Thiothixene) _____
- Prolixin (Fluphenazine) _____
- Risperdal, (Risperidone) _____
- Serentil (Mesoridazine) _____
- Seroquel, (Quetiapine) _____
- Stelazine (Trifluoperazine) _____
- Thorazine (Chlorpromazine) _____
- Trilafon (Perphenazine) _____
- Zyprexa, (Olanzapine) _____

MEMORY

- Aricept (Donepezil) _____
- Exelon (Rivastigmine) _____
- Namenda (Memantine) _____
- Reminyl (Galantamine) _____