Pacific Island Consulting LLC DBA Mindful Living Group

1300 N. Holopono Street, Suite 108, Kihei, HI 96753
P.O. Box 1977, Kihei, HI 96753
T 808-206-9371 | F 855-270-7441

Child & Adolescent Integrated Intake Assessment Form

This form is intended as a confidential screening form to assist you in informing your provider about your child's presenting problem. A complete evaluation is necessary to establish a diagnosis. You may be asked more questions about some of these items to pinpoint problems your child may have. Please answer each question to the best of your ability in the space provided. ***Thank you for choosing and trusting us.***

Child/Patient Name:		Birth Date:	
Address:			
Form completed by:	□ Parent □ Foster Parent □ Guardian □ Other:		
Gender:	□ Male □ Female		
School:		Grade:	
Referred by:	□ Parent/Guardian □ Pediatrician □ School □ CPS □ Court Order □ Other:		
Parent's Phone(s):		□ Cell □ Home	
		□ Cell □ Home	
		□ Cell □ Home	
Parent's Email:			
Therapist may leave a message at:	□ Cell □ Home □ Parent Email		

1. Child's main problem/major reason for seeking help at this time?

2. How long has your child had these problems, symptoms, or issues?

3. Has your child had treatment for these issues in the past?	□ Yes □ No If yes, was the outcome helpful? □ Yes □ No
Has your child had inpatient mental health treatment? If yes, briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:	□ Yes □ No

4. Describe any other behavioral or emotional problems your child is having:	
5. Describe the impact of your child's problems on the family.	
6. Describe your child's strengths and unique qualities:	
7. Is your child currently under the care of a physician or psychiatrist?	□ Yes □ No If yes, doctor's name: Treatment for:
Is your child currently taking any medications?	□ Yes □ No If yes, list name of medication, dosage, prescribed by
8. Does this child have a history of abuse (physical, sexual, emotional, neglect)?	□ Yes □ No If yes, please describe briefly, including dates, location, perpetrators, type of abuse and impact on child/family.
Is there legal action pending related to accusations of abuse?	□ Yes □ No If yes, describe briefly:

9. Is there any other legal action that may have impacted your child? Please check all that apply, and describe briefly:

	Now	**Past**
Custody		
Visitation		
Adoption		
CPS		
Probation		
Other		

10. Please check any of the following **behaviors** that concern you about your child:

	Now	Past		Now	Past
Crying, sadness, depression			Temper outbursts		
Loss of enjoyment of usual activities			Irritability, anger		
Expressing a wish to die			Argues a lot		
Bedtime fears, won't sleep			Disobedience		
Has threatened/attempted suicide			Does things that annoy others		
Worries more than others			Unusual fears or phobias		
Panics			Anxious, nervous		

Repeats unnecessary act over and over			Wakes up frequently at night		
Has rituals, habits, superstitions			Twitches or unusual movements		
Eats very little/fasts to lose weight			Gorges or binge eats		
Sleepwalking			Blames others for own mistakes		
Withdrawn			Easily annoyed by others		
Nightmares, night terrors			Swears or uses obscene language		
Low self-esteem			Wanting to run away		
Is overly concerned about things			Sneaks out at night		
Tiredness, fatigue			Injures self		
Restless sleep, wakes frequently			Stealing		
Trouble going to sleep			Lying		
Sleeps too much			Hurts animals		
Poor appetite			Destroys property		
Under or overweight			Hurts people		
Over-activity			Drug use		
Frequently acts without thinking			Alcohol use		
Doesn't finish things			Cigarette use		
Disruptive			Sexual problems		
Short attention span			Problems with authority		
Daydreams, fantasizes			Problems with the law		
Easily distracted			Low motivation		
Hallucinations			Vomits intentionally		
Bedwetting/daytime wetting			Soiling (pooping) in pants		
Strange or unusual behavioral			Disorientation		

11. Which forms of discipline are used in the home?	◻ None ◻ Time out ◻ Loss of privileges ◻ Grounding ◻ Extra chores ◻ Rewards/incentives ◻ Physical/corporal punishment ◻ Other, please describe:

12. Check each item that describes your child's **Relationship Development**:

	Now	Past		Now	Past
Prefers to be alone			Is demanding and bossy		
Poor relationships with teachers			Fights with others		
Is shy			Bullies others		
Has few friends			Teases a lot		
Has many friends			Plays with younger kids		
Plays with "problem kids"			Plays with older kids		
Is picked on a lot			Poor relationships with peers		
Is oversensitive			Conflict with parents/step-parents		
Alone a lot, but dislikes this and feels lonely			Has difficulty getting along with brothers and sisters		

13. Check each item that describes your child's **School Performance**:

	Now	Past		Now	Past
Dislikes school			Missed many school days		
Works hard, but does not do well			Repeated a grade		
Learning problems			Discipline referrals, detentions		
Unmotivated, refuses to complete work					

If your child has been suspended or expelled, how often, and why?	
Does your child have an IEP? If yes, please share what it is for.	◻ Yes ◻ No

14. Check each item that describes your child's **School Environment**:

	Now	Past		Now	Past
Resource classes/special education			Other programs		
Gifted program			Home study		
Therapy, e.g. Speech			Independent study		

15. Check **Family Stresses** that apply:

	Now	Past		Now	Past
Marital problems			Housing problems		
Marital separation			Legal issues		
Divorce			Death of a friend		
Custody disputes			Death of a relative		
Financial problems			Death of a pet		
Job loss			Family illness		
Parents using alcohol/drugs			Other, please describe:		

16. **Life Style & Social Activities**

Exercise If yes, type & frequency:	◻ Yes ◻ No		
Television hours/day		Social Media/Internet hours/day	
Clubs/groups/sports affiliations			
Hobbies			
What time does your child go to sleep, resp wake up?			
Does your child have a structured routine?	◻ Yes ◻ No		

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Describe your child's personality!	

17. **Developmental History**

Did any of the following apply to Mother during pregnancy. If yes, please explain:

- ◻ alcohol
- ◻ drugs
- ◻ illness
- ◻ accident
- ◻ problems with pregnancy
- ◻ problems with labor
- ◻ problems with delivery

Please check if child is/was delayed in any of the following areas, and briefly explain any delays:

- ◻ turning over
- ◻ sitting up
- ◻ crawling
- ◻ walking alone
- ◻ weaning
- ◻ feeding self
- ◻ toilet training
- ◻ using single words
- ◻ using sentences
- ◻ dressing self
- ◻ sleeping through the night

As a baby/toddler, was child:

- ◻ eating well
- ◻ colicky
- ◻ head banging
- ◻ performing rocking behavior
- ◻ clumsy
- ◻ easy to regulate (sleeping / eating)
- ◻ wanting to be left alone
- ◻ adaptable to transitions
- ◻ more interested in things than people
- ◻ easy to soothe
- ◻ performing daredevil behavior

18. Indicate if your child has had any of the following in their **Medical History**:

Condition	Yes	Age	Details
Serious Infection			
Convulsions/seizures			
Head injuries			
Other injuries			
Hospitalizations			
Surgeries			
Ear infections			
Poisonings			
Allergies			
Asthma			
Alcoholism			
Drug Use			
Sexual Problems			

Does your child have any other medical conditions? If yes, please describe:	◻ Yes ◻ No

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Does your child frequently complain of bodily aches and pains? If yes, please describe:	◻ Yes ◻ No
Does your child miss school because of his/her physical complaints? If yes, please describe:	◻ Yes ◻ No
Does your child have any allergies to medications, drugs or foods? If yes, please describe:	◻ Yes ◻ No

19. Please list child's **family** members:

Relationship	Name	Lives with child?	Age	Quality of relationship
Mother				
Father				
Step mother				
Step father				
Siblings				
Other Relatives				

19. Indicate if any family members or relatives have the following problems:

	Mother		Father		Sister		Brother		Other relatives	
	Now	Past	Now	Past	Now	Past	Now	Past	Now	Past
Problems with attention, activity or impulse control										
Learning disabilities										
Not graduated from high school										
Alcohol abuse										
Drug use										
Problems with aggressive behavior, as an adult or child										
Antisocial behavior (jail, legal problems, arrests, probation)										

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Abuse victim										
Abusive to others										
Depression										
Nervous disorders										
Mental retardation										
Serious illness or surgeries										
Physical handicaps										
Tics or unusual movements										
Other mental problems										

What are your family supports? (church, friends, clubs etc.)	
What are your family strengths?	

List any adults (name and relationship) who are authorized to drop off or pick up your child from his/her therapy session in the event you or another legal guardian are unavailable.

AN AUTHORIZED ADULT MUST REMAIN IN THE WAITING ROOM AT ALL TIMES WHEN A MINOR (ANYONE UNDER 18) IS IN A THERAPY SESSION.

I authorize the above named person(s) to drop off or pick up my child from his/her therapy session. I agree that I or any person named by me (listed above) will not leave the premises and will remain in the waiting room for the duration of my child's therapy session.

Child/Patient Name:		Birth Date:	
Parent/Guardian Name:		Relationship to child:	
Signature:		Date:	