Rose Street Mental Health Care
Day School Entry Assessment

IDENTIFICATION SECTION

Patient Name ______________________ Date/Time of Admission ______________

Program: ___Child ___Adolescent DOB __________ Age _____ Race __________ Sex: ___M ___F

Emergency Contact & Phone Number ______________________________________

Relation to Patient *Phone Number*

Referral Source ______________________ Accompanied by ______________

SOCIO CULTURAL SECTION

Biological Father ______________________ Age _____ Living in home? ___Yes ___No

Biological Mother ______________________ Age _____ Living in home? ___ Yes ___No

Adults in the home: (***name, age, relationship***)

____

____

____

____

Children in the home: (***name, age, relationship***)

____

____

____

____

What school do you attend? ______________________ Grade ________

Have you ever repeated a grade? ___Yes ___No Grade(s) repeated? ______________

Are you in any special education classes? ___Yes ___No Explain ______________

What kind of grades do you make in school? ______________________

Are you experiencing problems at school now? ___Yes ___No Explain ______________

____

When did you first become aware of the problem(s)? ______________________

What do you think is causing the problem(s)? ______________________

____

Have you been evaluated by a school or private agency within the last 3 years? ___ Yes ___ No

If yes, when and by whom? ______________________

Have any family members had learning problems? ___ Yes ___ No Explain ______________

____

What is your bedtime? ______________ Do you eat breakfast on a regular basis?___ Yes ___ No

What type of activities do you enjoy with your family (***example***: *watch TV, go camping, sports, etc*)? ________

____

How do you spend your spare time (***example:*** *watch TV, read, household chores, part-time job, play with other children, etc*)? ______________________________________

What significant relationships do you have outside of the home? ______________________________________
____

Are you involved with any clubs, organizations, or church support groups? ___ Yes ___ No Explain ___________
____

Do you have any religious or cultural beliefs or practices? ______________________________________

Have there been any important changes within the family during the last 3 years (***example:*** *job changes, moves, births, deaths, illnesses, separations, or divorce, etc*)? ______________________________________
____

What is your behavior at home? ______________________________________
____

Do you get along with other Family Members? ___Yes___No ***Neighbors?*** ___Yes___No ***Friends?*** ___Yes ___No

What conflicts do you have with your family? ______________________________________
____
____

What methods of discipline are used in the home (***example:*** *extra chores, early bedtime, positive rewards, etc*)?
____
____

HEALTH HISTORY

Primary Care Physician ______________________________ Phone # ______________

Current Disabilities ______________________________________

Were there any problems before, during, or immediately after birth? ___ Yes ___ No Explain ___________
____

Were drugs or alcohol used during pregnancy? ___ Yes ___ No How much? ______________

Compared to other children in the home, were major milestones ___ ***slower,*** ___ ***about the same,*** ___ ***faster***?

Are there any physical development problems? ___ Yes ___ No Explain ______________
____

Is there any history of head trauma? ___ Yes ___ No Explain ______________
____

Have there been any recent physical or health problems? ___ Yes ___ No If *yes*, list below.

Problem	Treatment	Date	By Whom/Where

Are there any chronic medical conditions (***example***: *diabetes, heart condition, etc.*)? ___ Yes ___ No
Explain ____
____

Is there a history of ear infections? ___ Yes ___ No Explain ____________________________
Are you allergic to any medications? ___ Yes ___ No If ***yes***, list medication, dose, and reaction experienced:
____
____

Do you have food allergies or environmental allergies? ___ Yes ___ No If ***yes***, list ______________
____

Are there any prior hospitalizations?

Medical ___ Yes ___ No Explain ____________________________
Surgical ___ Yes ___ No Explain ____________________________

Is there a current need for a medical referral? ___ Yes ___ No Explain ______________
____

List any medications your child is presently taking:

Medication Name	Frequency	Dose	Start Date	Last Dose (date & time)

Somatic symptoms? ___ Yes ___ No ___*Headaches* ___*Stomach aches* ___*Chronic pain*
Other ____
How often/Type of relief? ____________________________

PSYCHIATRIC HISTORY

Have you, or are you currently receiving outpatient therapy? ___ Yes ___ No With whom? ___________
Last seen? ___________ Reason for therapy? ___________ How long? ___________

Have you, or are you currently being seen by a psychiatrist? ___ Yes ___ No Physician ___________
Last seen? ___________ How long? ___________ Why? ___________

Have you been previously hospitalized for psychiatric or chemical dependency? ___ Yes ___ No
Name of Hospital ___________ Date(s) ___________

Have you previously attended the Rose Street School? ___ Yes ___ No When? ___________

Has anyone in your family had psychiatric problems? ___ Yes ___ No Whom? ___________
Diagnosis/Medications ___________

Have you ever had any hallucinations? ___ Yes ___ No ___*Visual* ___*Auditory* ___*Other*
Explain ___________

Please check specific behaviors below:

___ Fails to pay close attention to details
___ Difficulty staying on task
___ Does not follow directions, especially multi-step
___ History of impulsivity
___ Bullies, threatens or intimidates others
___ Deliberately engaged in fire setting
___ Has run away from home overnight
___ Argues with adults
___ Deliberately annoys people
___ Easily annoyed by others, touchy
___ Unforgiving (Spiteful)
___ Appetite decreased/increased
___ Weight gain or loss
___ Loss of energy
___ Social isolation
___ Sad mood
___ Sudden loss of concentration
___ Trouble telling the truth
___ Increase in goal-directed activity
___ Accelerated heart rate
___ Restlessness or feeling on edge
___ Muscle tension
___ Curses
___ Throws things
___ Hits people
___ Recurrent and persistent thoughts that cause distress
___ Blames others for his/her mistakes or misbehavior
___ Bites
___ Driven to perform with repetitive behaviors
___ Makes careless mistakes in schoolwork
___ Does not appear to listen when spoken to
___ Difficulty organizing or losing things
___ Has used a weapon to threaten physical harm
___ Deliberately destroyed others' property
___ Truant from school
___ Actively refuses to comply with adults' requests
___ Done wrong (Resentful)
___ Lack of interest in pleasurable activities
___ Sleep disturbance
___ Feelings of worthlessness and/or guilt
___ Mood Swings
___ Recurrent thoughts of death
___ Inflated self-esteem
___ Flight of ideas
___ Panic attacks
___ Trembling hands
___ Irritability
___ Anger outbursts
___ Yells
___ Hits objects other than people
___ Kicks
___ Withdraws from family and friends
___ Distress when separated from attachment figures
___ Risk taking behaviors: ___________

RISK ASSESSMENT

Check all that apply

Suicidal/Self-Injury ___ Patient denies ___ No evidence of ___ Death Wish

___ Recent Losses ______________________________

___ Suicidal ideation/threats with no plan ___ Suicidal gesture without intent

___ Suicidal intent with plan; specify plan ______________________________

Access to means; specify ______________________________

___ Self-mutilation injury present; specify ______________________________

___ Suicide attempt within 48 hours; specify ______________________________

___ Prior suicide attempts; describe ______________________________

___ Family history of suicide; describe ______________________________

___ History of self-mutilation behaviors ______________________________

Violence ___ Patient denies ___ No evidence of ___ Harm to others wish

___ Harm to others ideation without plan

___ Family history of harm to others; specify ______________________________

___ Harm to others intent with plan; specify plan ______________________________

Access to means; specify ______________________________

___ Harm to others, attempt within last 48 hours; specify ______________________________

___ Prior harm to others, describe ______________________________

___ Access to weapons/other resources

Has parent(s) been asked to lock up weapon(s)? ___ Yes ___ No

SEXUAL ASSESSMENT

Sexually Active? ___ Yes ___ No Birth Control? ___ Yes ___ No Type ______________________________

CHEMICAL HISTORY

Does the patient have a *current* substance abuse problem? ___ Yes ___ No
Does the patient have a *previous* substance abuse problem? ___ Yes ___ No

Substance	Method of Use	Date Started	How Much	Frequency	Last Used
Alcohol					
Marijuana					
Cocaine					
Hallucinogens					
Heroin					
Tranquilizers					
Opiates					
Inhalants					
Barbiturates					
Amphetamines					
Tobacco					
Other:					

Is there a history of substance abuse in the family? ___ Yes ___ No Explain ______________________

____

____

ABUSE ASSESSMENT

The patient as victim:

___ History Physical Abuse ____

___ History Sexual Abuse ____

___ Emotional Abuse ____

___ Neglect ____

___ CPS Report Filed ____

Abuse Practices: (*patient has history or currently engaged in*)

___ Physical abuse of ____

___ Sexual abuse of ____

___ Ritualistic/Religious abuse ____

___ Gang involvement ____

LEGAL HISTORY

History of Previous Charges (*list below*):

Charges/Dates	Probation Officer	Requirements

PRESENTING PROBLEMS

Were there any precipitating events within the last 24 hours? ____________________

____

____

____

Sleep As evidenced by frequency, intensity, duration

Difficulty going to sleep (*initial insomnia*) ___ Yes ___ No

Frequent awakening during night (*mid-insomnia*) ___ Yes ___ No

Early morning awakening (*terminal insomnia*) ___Yes ___ No

Sleeps all day ___ Yes ___ No

Unusual number of hours of sleep ____________________

____