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 Howmuch? _____

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? ☐ Y ☐ N (if yes please list below)

Date	Problem	Treatment	Physician Name

Are there any chronic medical conditions (ex: diabetes, heart condition, etc?) ☐ Y ☐ N

Please explain: _____

_____

Is there a history of ear infections? ☐ Y ☐ N Please Explain: _____

Are you allergic to any medications? ☐ Y ☐ N (If yes please list below)

_____

_____

Do you have food or environmental allergies? ☐ Y ☐ N (If yes, please list below)

_____

_____

Are there any prior hospitalizations? ☐ Y ☐ N (If yes please list below)

Is there a current need for a medical referral? ☐ Y ☐ N

List any medications your child is presently taking below:

Medication Name	Dose	Frequency	Start Date	Last Dose (Date/Time)

Somatic Symptoms? ☐ Y ☐ N ☐ Headaches ☐ Stomach Aches ☐ Chronic Pain

Other_____

How often? What 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 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/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 of feeling on edge
- ☐ Muscle Tension
- ☐ Curses
- ☐ Throws things
- ☐ Hits people
- ☐ Recurrent and persistent thoughts that cause distress
- ☐ Blames other for his/her mistakes/behavior
- ☐ 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; specify _____

☐ 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? ☐ Y ☐ N

Does the patient have a **previous** substance abuse problem? ☐ Y ☐ N

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

Is there a history of substance abuse in the family? ☐ Y ☐ N

Please explain: _____

_____

ABUSE ASSESSMENT

Patient as victim:

Physical Abuse: _____

Sexual Abuse: _____

Emotional Abuse: _____

Neglect: _____

CPS Report Filed?: _____

Abuse Practices (patient has history or currently ongoing):

Physical Abuse of: _____

Sexual Abuse of: _____

Ritualistic/Religious Abuse: _____

Gang Involvement: _____

LEGAL HISTORY

History of Previous Charges *(list below):*

; <::harges/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 _____

_____