Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

## Social History

Medical issues (past and current): _____

_____

Surgeries (what and when): _____

_____

Drug/Food/Other Allergies (please list reaction): _____

_____

_____

Last physical exam (month/year): _____ By Whom: _____

Last Dental exam (month/year): _____ By Whom: _____

Braces and or retainer? _____

Last Eye exam (month/year): _____ By Whom: _____

Glasses or contacts?

**Student's relationship with family members**: _____

_____

_____

**Contact with extended family**:

Maternal: _____

_____

Paternal: _____

**Religious Practices**:

Preference: _____

Attendance: _____

Activities or programs:

**Childhood History**:

Complications during Pregnancy: _____

_____

Complications at birth: _____

_____

Developmental Milestones met average times? _____If no, which ones were delayed? _____

_____

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

**Events of early childhood**: (Since birth has the child experienced any of the following):
Parents got married/separated/divorced/dated/remarried (who and when): _____

Witnessed domestic Violence (by who and when): _____

Losses/deaths: _____

Traumas: _____

Injuries: _____

Parent(s) extended medical issues/hospitalizations etc.: _____

Parent(s) legal issues to include jail/prison time: _____

Moves during life (from where to where and when): _____

**Financial Status**:
Student's work history: _____

Adoption Subsidy (how much?) _____ SSDI (how much?) _____

Child Support (how much?) _____ Other financial support _____

Where Mom and/or Stepmother works and when: _____

Where Dad and/or Stepfather works and when:_____

**Friendships**:
Can the student make and maintain friendships? _____

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

What is the student able to do with his/her friends? _____

_____

Are student's friends positive or negative influence? _____

How?_____

**Sexualized Behavior:**
Has student displayed sexualized behavior? _____

If yes, describe what they are: _____

_____

**Family History**:
**Issues pertaining to Mom**:
Medical issues: _____

Legal issues: _____
**Issues of Maternal side of family**:
Medical issues: _____

Legal issues: _____
**Issues pertaining to father**:
Medical issues: _____

Legal issues: _____

**Issues for paternal side of family**:
Medical issues: _____

Legal issues:

**Student substance use/abuse/dependence**: (describe usage and age started)

Alcohol: _____

Marijuana/street drugs: _____

Prescription drug abuse: _____

Over the counter medications: _____

Caffeine: _____

Energy drinks: _____

Nicotine:

**Strengths of family**: _____

_____

_____

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

**Community resources used by family**:
Sports:
_____

Boy/Girl Scouts, 4-H etc:
_____

YMCA/Boys-Girls club etc:
_____

Groups or activities Participated In:

**History of Abuse**: by who and when

Emotional:
_____

_____

Physical: _____

_____

Sexual:
_____

IQ Testing? Yes _____ No _____

When, where, results?

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

Any additional information: _____

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

CHILDREN'S SQUARE U.S.A.

## CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC SERVICES

INDEPENDENT TEAM ASSESSMENT

| YES | NO | |
|---|---|---|
| X | | 1. Available community resources for ambulatory care do not meet the treatment needs of this child. |
| X | | 2. Proper treatment of this child's psychiatric condition requires service on a residential inpatient basis under the direction of a physician. |
| X | | 3. These services can reasonably be expected to improve this child's condition or prevent regression so that the services will no longer be needed. |

Physician's Signature (M.D. or D.O.) Date

Printed Name & Credentials

Professional's Signature Date

Printed Name & Credentials

Professional's Signature Date

Printed Name & Credentials

X/Karen - Dir/BP:sb
Rev. 04/95-05/07-08/12

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

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**I hereby authorize** _____
(name/agency and address)

**to release to** **Children's Square USA, PO Box 8-C, Council Bluffs 51502 fax: 712-325-8200**
(name/agency and address)

**the records of:** Name: _____
Last First MI Previous Name

**Covering the periods of healthcare (Date(s) of service):**
From (date) _____ To (date) _____
**For the purpose of:** PMIC placement evaluation
Please check one: ( ) On-going information request valid for one year ( x ) one time information request valid for 90 days

Specific Authorization for Release of Information protected by State or Federal Law
*I understand that the information to be released may include information in the following categories Client must (Initial) appropriate categories:*

Mental Health _____

Substance Abuse _____ (alcohol/drug abuse-client must check & sign regardless of age) _____
Client Signature, age 12 & older (only when releasing info)

Check all that apply:

| | | |
|---|---|---|
| (X) Psychiatric Evaluation | (X) Psychiatric Notes | (X) Grade Reports |
| (X) Therapy Intake | (X) Therapy Progress Notes | (X) Individualized Education Program |
| (X) Laboratory Results | (X) Immunizations | (X) Other School Information |
| (X) Psychological Evaluation | (X) Social History | (X) Treatment Plan |
| (X) Discharge summary | ( ) Other (please specify) _____ | |

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Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

CHILDREN'S SQUARE USA
CHEMICAL ABUSE/DEPENDENCY ASSESSMENT

Chemical Abuse/Dependency History

| **Drug Type** | **Frequency of use** (daily, several times a week, once a week, several times per month, tried, does not use) |
|---|---|
| Alcohol | |
| Marijuana | |
| Street drugs | |
| Prescription drug abuse | |
| Over the counter medications | |
| Caffeine | |
| Energy drinks | |
| Nicotine | |
| Other | |

Past Chemical Abuse/Dependency Treatment

Assessments/evaluations:

SASSI (where and when):
Evaluations (where and when):

Inpatient Treatment:

Hospital:
Treatment Facility:

Out Patient Treatment:

Day Treatment:
Group Therapy:
Individual Therapy:
Family Therapy:
AA/NA :

How has drug/chemical use affected your child or family?

_____

_____

_____

_____

_____

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

Trauma/Loss Exposure Form

Child's Name: _____ Age: _____
Form Completed by (Name): _____ Date: _____
Reason for Current Evaluation (check all that apply):
Baseline Assessment: New Client: _____
Other (Specify): _____

Trauma/Loss Exposure History:

| **Trauma Type** | **Yes/Suspected No/Unknown** | **Age(s) Experienced (be specific)** |
|---|---|---|
| Sexual Abuse or Assault/Rape | | |
| Physical Abuse or Assault | | |
| Emotional Abuse/Psychological Maltreatment | | |
| Neglect | | |
| Serious Accident or Illness/Medical Procedure | | |
| Witness to Domestic Violence | | |
| Victim/Witness to Community Violence | | |
| Victim/Witness to School Violence | | |
| Natural or Manmade Disasters | | |
| Forced displacement | | |
| War/terrorism/Political Violence | | |
| Victim/Witness to Extreme Personal/Interpersonal Violence | | |
| Traumatic Grief/Separation (does not include placement in foster care) | | |
| Systems Induced Trauma | | |

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

B. Current Traumatic Stress Reactions

| **Reaction** | **Yes/No/Unknown** | **Definition** |
|---|---|---|
| Re-experiencing | | *These symptoms consist of difficulties with intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. Also included is pronounced reactivity to trauma or loss reminders. These symptoms are part of the DSM-IV criteria for PTSD.* |
| Avoidance | | *These symptoms include efforts to avoid stimuli associated with traumatic experiences. The child may avoid certain places or people, or avoid discussing the specifics of the trauma. These symptoms are part of the DSM-IV criteria for PTSD.* |
| Numbing | | *These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses were not present before the trauma. Numbing symptoms include feelings of detachment or estrangement from others, restricted range of emotion (e.g., unable to have loving feelings), feeling out of sync with others, or having a sense of a foreshortened future.* |
| Arousal | | *These symptoms consist of difficulties with hypervigilance (an exaggerated awareness of potential dangers), difficulty concentrating, exaggerated startle reactions, difficulties falling or staying asleep, and irritability or outbursts of anger. Children with these symptoms often seem distractible, impulsive and inattentive, leading to a common misdiagnosis of ADHD.* |

C. Attachment

| Attachment Issues | **Yes/No/Unknown** | *This category refers to a child's difficulty forming or maintaining relationships with significant parental or caregiver figures. It relates to the child's sense of security and trust in interacting with others. Often children with attachment difficulties interact with new acquaintances in unusual ways. They may bond too quickly (e.g., hugging strangers and climbing on their laps), or fail to engage in appropriate ways (e.g., avoid eye contact and fail to engage in appropriate conversations/interactions).* |
|---|---|---|

D. Behaviors Requiring Immediate Stabilization

| Behavior | | | |
|---|---|---|---|
| Suicidal Intent | Yes | No | Unknown |
| Active Substance Abuse | Yes | No | Unknown |
| Eating Disorder | Yes | No | Unknown |
| Serious Sleep Disturbance | Yes | No | Unknown |

Name: DOB: AGE: Gender:
CSUSA #: Title 19: Legal Status:

E. Current Reactions/Behavior/Functioning

| **Regulation of Emotion** | **Yes/No/Unknown** Does this interfere with child's daily functioning at home, in school or in the community | **How to recognize Problem Behaviors** (check Yes if child presents with any of the descriptors listed below) |
|---|---|---|
| Anxiety | | *Anxious children often appear tense or uptight. Worries may interfere with activities and they may seek reassurance from others or be clingy. These children may be quiet, compliant and eager to please, so they may be overlooked. Anxious children may report phobias, panic symptoms, and report physical complaints, startle easily, or have repetitive unwanted thoughts or actions.* |
| Depression | | *Depressed children may appear tearful/sad, show decreased interest in previous activities, have difficulty concentrating, or display irritability. They may present with depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, loss of motivation, verbal aggression, sullenness, grouchiness, hopelessness, or negativity. They may have frequent complaints o( physical problems.* |
| Affect Dysregulation | | *Children with affect dysregulation may have difficulty expressing specific feelings, whether positive or negative, and may have trouble fully engaging in activities. They may have problems modulating or expressing emotions, experience intense fear or helplessness, or have difficulties regulating sleep/wake cycle.* |
| Dissociation | | *Children experiencing dissociation may daydream frequently. They may seem to be spacing out and be emotionally detached or numb. They are often forgetful and sometimes they experience rapid changes in personality often associated with traumatic experiences.* |
| Somatization | | *Somatization* is *characterized by recurrent physical complaints without apparent physical cause. Children may report stomachaches or headaches, or on the more serious end of the spectrum, they may report blindness, pseudoseizures, or paralysis.* |
| Attention Concentration | | *Children with problems with attention, concentration and task completion often have difficulty completing schoolwork or may have difficulty forming strong peer relationships.* |
| **Regulation of Behavior** | **Yes/No/Unknown** | **Includes risky behaviors.** |
| Suicidal Behavior | | *Includes both superficial and more serious actions with potentially life-threatening consequences. Examples include overdosing, deliberately crashing a car, or slashing wrists.* |
| Self-Harm | | *When someone deliberately harms him or herself. Includes cutting behaviors, punching oneself, pulling out hair or eyelashes, picking skin causing sores, burning, inhaling or overdosing on medications.* |
| Regression | | *Child ceases using previously adaptive behaviors. Child may begin wetting or soiling themselves after they had been potty trained, and may begin using baby talk or refusing to sleep alone when these skills were previously mastered.* |
| Impulsivity | | *Acting or speaking without first thinking of the consequences.* |
| Oppositional Behaviors | | *Defined by negativistic, hostile and defiant behaviors. Child may lose temper frequently, argue with adults, and refuse to comply with adult rules. Child may deliberately annoy people and blame others for mistakes or misbehaviors.* |
| Conduct Problems | | *Defined by a variety of different conduct problems. Child may be physically or verbally aggressive to other people or animals. Children with conduct problems may destroy property, steal, break the law, or start fires. They may run away from home or act in a sexually promiscuous or aggressive fashion.* |