

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
<p>Depression – Has your child had a period of time in which he/she felt unhappy, depressed, irritable, and felt no interest in life consistently for at least two to four weeks? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>High Periods or Mania – Has your child had moods that lasted one week or more in which he/she had so much energy he/she did not sleep for several nights, or felt he/she could accomplish many difficult tasks easily? Was he/she feeling so good that others commented on his/her elevated mood? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Chronic Feelings of Unhappiness – Has your child felt mildly unhappy or unable to enjoy life for many years, for no apparent reason? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Suicide Attempts – Has your child attempted suicide? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Self Harm – Besides attempting suicide, has your child attempted to do physical harm to him/herself in other ways, such as cutting or burning him/herself? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Chronic Tension or Anxiety – Has your child ever had problems with chronic anxiety, tension, nervousness, or constant worrying? Does he or she worry about minor concerns? (Not connected to anxiety attacks) <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Panic Attacks – Has your child had anxiety attacks in which he/she felt like they were going to die, lose control, were very frightened, extremely anxious, or uncomfortable? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Panic Associated Fears – Has your child ever been afraid of going out of the house alone, going to the grocery store, driving or using public transportation because of fear of having a panic attack? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Obsessive/Compulsive Symptoms – Has your child had compulsions to repeat tasks such as checking things, washing hands, counting, or obsessions (ideas that make no sense but keep repeating in his/her mind?) <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Social Fears or Phobias – Has your child been fearful in specific social situations, or felt uncomfortable doing things in front of other people? Does he/she worry excessively about being embarrassed or humiliated in social situations? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p> <p>Phobias – Has your child had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with his/her life? <input type="checkbox"/> Yes, now. <input type="checkbox"/> Yes, in the past. <input type="checkbox"/> No</p>	

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems

Posttraumatic Symptoms – Has your child ever experienced a very traumatic event that has continued to bother him/her or cause emotional problems later in life, such as nightmares or flashbacks of the event?

- Yes, now. Yes, in the past. No

Hyperactivity/Inattention – Was/is your child considered hyperactive and/or inattentive, been treated with Ritalin or another stimulant, or been diagnosed with ADHD?

- Yes, now. Yes, in the past. No

Psychotic Symptoms – Has your child had hallucinations, heard voices, felt that he/she had special powers or were receiving special messages, felt inappropriately suspicious that people were trying to hurt him/her?

- Yes, now. Yes, in the past. No

Chronic Physical Symptoms – Has your child had a period of time in which he/she felt physically sick or worried about his/her health when no physical cause could be found?

- Yes, now. Yes, in the past. No

Chronic Pain – Has your child had problems with chronic pain such as headaches or stomachaches?

If so please specify: _____

- Yes, now. Yes, in the past. No

Sleep Problems – Has your child experienced sleep problems such as insomnia, oversleeping, frequent nightmares or sleepwalking?

- Yes, now. Yes, in the past. No

Anorexia – Has your child ever been anorexic or purposely lost weight to obtain a weight below normal?

- Yes, now. Yes, in the past. No

Binge Eating or Bulimia – Has your child had eating binges associated with inducing vomiting, using laxatives, or exercising to extreme?

- Yes, now. Yes, in the past. No

Compulsive Behaviors – Has your child had problems with compulsive behaviors such as gambling, spending, work, sex, pornography, or other problematic compulsions?

- Yes, now. Yes, in the past. No

Temper/Anger Problems – Has your child had problems with his/her temper?

- Yes, now. Yes, in the past. No

Oppositional Behaviors – Does your child argue with adults, defy rules, deliberately annoy others, blame others for his/her misbehavior, or act easily annoyed more than his/her peers?

- Yes, now. Yes, in the past. No

Conduct Disorder Problems – Has your child repetitively exhibited threatening behavior, cruelty to animals, fire-setting, destruction of property, shoplifting, stealing, lying, running away, running away, truancy, gang activity, etc.?

- Yes, now. Yes, in the past. No

For Clinician Use Only:

Client Name: _____

(3) BEHAVIORAL HEALTH TREATMENT HISTORY

	Who provided the service?	When and how often?	Was it helpful? Please explain.
Counseling			
Medication Management			
Family Therapy			
Case Management			
CBRS/PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
IEP or 504 Plan			
Personal Care Services			
Other			

Has your child been admitted to a residential treatment program or psychiatric hospital? No Yes – please complete:

Institution	Reason for admission	Date	Length of stay	Did it help?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(4) SUBSTANCE USE/ABUSE

Alcohol Use/Abuse – Does your child drink alcohol? Yes, now Yes, in the past No

He/she drinks occasionally: _____ x per month He/she drinks most days: _____ x per week

I believe he/she has a drinking problem.

Drug Abuse – Has your child abused “street” or prescription drugs? Yes, now Yes, in the past No

If yes, what drug(s) and what ages with each drug? _____

Smoking/Vaping/Other – Do you smoke, use other tobacco products, or vape? Yes, now Yes, in the past No

If yes how much per day/week and for how long? _____

Caffeine – Does your child regularly drink coffee, tea or colas? No Yes – How much? _____

Clinician Comments:

Client Name: _____

(5) FAMILY PSYCHIATRIC HISTORY

Please include psychiatric problems in your child's biological relatives. Consider problems such as depression, bipolar disorder, anxiety disorders (OCD, panic disorder, PTSD), schizophrenia, ADHD, alcohol or drug abuse, anger or criminal problems, suicides, etc.

Relative	Yes	No	?	Type(s) of problem(s)
Child's Mother				
Mother's Relatives				
Child's Father				
Father's Relatives				
Child's Siblings				

(6) MEDICAL HISTORY & FUNCTIONING

How is your child's general health? Good Fair Poor

Medical Doctors/Specialists: _____

History of significant illness or medical treatment in the family: _____

Health Conditions - Check any health conditions that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart problem | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Trouble eating | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |

Does your child have

- | | | | |
|--------------------------------|-----------------------------|------------------------------|------------------|
| any contagious diseases? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | What/When: _____ |
| any disabilities or handicaps? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | What/When: _____ |
| any allergies? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | What/When: _____ |

Client Name: _____

Has your child had any

- accidents/injuries? No Yes What/When: _____
- surgeries? No Yes What/When: _____
- major illnesses? No Yes What/When: _____
- hospitalizations? No Yes What/When: _____
- loss of consciousness? No Yes What/When: _____

Menstrual History – What was the date of your child’s last menstrual period? _____

Does your daughter have any history of:

- premenstrual syndrome? No Yes What/When: _____
- amenorrhea (absence of periods)? No Yes What/When: _____
- irregular periods? No Yes What/When: _____
- pregnancy? No Yes What/When: _____

Current Medication - Please list all current prescribed or over-the-counter drugs/medications.

No medications

- Medication: _____ Dosage: _____ Doctor: _____
- Medication: _____ Dosage: _____ Doctor: _____
- Medication: _____ Dosage: _____ Doctor: _____
- Medication: _____ Dosage: _____ Doctor: _____
- Medication: _____ Dosage: _____ Doctor: _____
- Medication: _____ Dosage: _____ Doctor: _____

Can your child self-administer his/her medication? No Yes

- Medication compliance: Regularly taken as prescribed Occasionally misses a dose
- Misses doses regularly Refuses/forgets to take meds most days

Past Medication - Has your child been treated in the past with psychiatric medication? No Yes – please complete:

Antidepressants		Mood Stabilizers	Tranquilizers	Sleeping Aids	Stimulants	Others
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Risperdal
Zoloft	Wellbutrin	Depakote	Klonopin	Sonata	Dexedrine	Zyprexa
Paxil	Amitriptyline	Tegretol	Ativan	Trazodone	Adderall	Seroquel
Luvox	Nortriptyline	Lamictal	Valium		Clonidine	Haldol
Celexa	Desipramine	Neurontin	Buspar		Concerta	Prolixin
Effexor	Anafranil	Abilify			Provigil	Thorazine
Remeron					Vyvanse	Trilafon
					Strattera	Antabuse

Clinician Comments:

Client Name: _____

DEVELOPMENTAL HISTORY

Early Development - Did your child or his/her mother experience any significant medical problems during the pregnancy, labor, delivery, or newborn period? No Yes – please explain: _____

Was his/her mother using alcohol, cigarettes, or illicit drugs during the pregnancy? No Yes – please explain: _____

Did your child ever spend a significant period of time separated from his/her primary caregiver(s) for any reason? No Yes – please explain: _____

Have you or your child’s pediatrician ever expressed concerns about your child’s development? No Yes – please explain: _____

Clinician Comments:

(7) FAMILY HISTORY & FUNCTIONING

Place of child’s birth: _____

Parents at the time of birth were: Married Separated Unmarried

Are the parents divorced? If so, when? _____ Remarriages? _____

Father’s Name: _____ Mother’s Name: _____

Where is he living: _____ Where is she living: _____

Stepmother’s Name: _____ Stepfather’s Name: _____

Custody: Lives in one home with both legal parents. Mother has physical custody.
 Father has physical custody. Physical custody is shared.
 Other: _____

Household members:	Name	Age	Relationship
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Client Name: _____

Siblings not in household:	Name	Age	Relationship
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

If any brothers/sisters are deceased, please give name and year: _____

Was the child adopted? No Yes – Age at time of adoption: _____ Circumstances: _____

FAMILY HISTORY:

Has the child ever been placed outside of the home? No Yes – please explain: _____

Has the child been physically or sexually abused, assaulted or molested? No Don't know Yes – please specify when and by whom: _____

Please describe the child's relationship with his/her

Father: _____

Mother: _____

Siblings: _____

Stepparent(s): _____

Please describe the type of structure and discipline used in the home: _____

Please explain your family's cultural and/or spiritual background: _____

Where did the child live while he/she was growing up? Did the family move frequently? _____

What resources and supports does the child/family have? _____

What are the child's strengths in the family setting? _____

Clinician Comments:

Client Name: _____

(8) SOCIAL HISTORY & FUNCTIONING

How would you describe your child's friendships? No friends Only acquaintances Acquaintances & Friends

How would you describe your child's behavior when he/she is in social situations? _____

Has your child experienced any difficulties related to age, gender, sexual orientation, culture, race, or religion? No Yes – please explain: _____

Is your child sexually active or does he/she demonstrate overly sexualized behavior? No Yes – please explain (number of partners, risky behavior, etc): _____

What leisure/recreational/extracurricular activities is your child involved in? _____

What are your child's talents and social strengths? _____

Clinician Comments:

(9) VOCATIONAL/EDUCATIONAL HISTORY & FUNCTIONING

Education - School: _____ Grade Level: _____

Is your child in a specialized classroom setting or receive special education? No Yes – please explain: _____

Regarding school, has your child ever

had an IEP or 504 plan? No Yes – please explain: _____

been tutored? No Yes – please explain: _____

been suspended? No Yes – please explain: _____

been expelled? No Yes – please explain: _____

Have you been contacted by school personnel because of your child's school performance or behavior? No Yes – please explain: _____

What are the average grades your child received:

in elementary school? _____

in junior high? _____

in high school? _____

What are your child's strengths/talents in the school setting? _____

Client Name: _____

Employment - Has your child ever been employed? No Yes – please describe job(s) and duration of employment: _____

Has your child ever

been reprimanded at work? No Yes – please explain: _____

been fired from a job? No Yes – please explain: _____

participated in a work program? No Yes – please explain: _____

What are your child's work skills/interests? _____

Clinician Comments:

(10) FINANCIAL HISTORY & FUNCTIONING

Please describe the family's source(s) of income: _____

Are finances adequate to meet the family's needs? Yes No – please explain problems and supports/resources available: _____

Does the child/family receive

child support? No Yes – amount/frequency: _____

SSDI? No Yes – amount/frequency: _____

SSI? No Yes – amount/frequency: _____

food stamps? No Yes – amount/frequency: _____

cash assistance? No Yes – amount/frequency: _____

other income? No Yes – amount/frequency: _____

Please explain any financial responsibilities/obligations your child has and how he/she manages these responsibilities: _____

Clinician Comments:

(11) BASIC LIVING SKILLS HISTORY & FUNCTIONING

Please indicate your child’s habits with regard to the following basic living skill practices:

Bathing (using soap, washing hair) Daily A few times per week Once per week or less

Brushing teeth Daily A few times per week Once per week or less

Dress in clean/appropriate clothes Daily A few times per week Once per week or less

Does your child require repeated prompting in order to accomplish any of these hygiene tasks? No Yes

Is your child able to perform the following basic safety skills?

Call 911 in an emergency? Yes No

Refrain from playing with matches or other fire hazards? Yes No

Use adequate caution when crossing the street? Yes No

Use adequate caution when engaging with strangers (is she/he aware of stranger danger?) Yes No

Lock doors and use a key? Yes No

Please indicate your child’s care of his/her personal possessions: Good care/age appropriate Careless Destructive

Will your child be turning 18 soon and/or preparing to live on his/her own? No Yes – if “yes”, please indicate your child’s ability to do the following:

Prepare meals Good Fair Poor

Shop for items Good Fair Poor

Develop regular schedules/routines Good Fair Poor

Clinician Comments:

(12) HOUSING HISTORY & FUNCTIONING

Does the current housing situation meet the child’s needs in the following areas?

Health and safety? Yes No – please explain: _____

Access to services? Yes No – please explain: _____

Is there any history of homelessness? No Yes – please explain: _____

Is there any risk of homelessness? No Yes – please explain: _____

Clinician Comments:

Client Name: _____

(13) COMMUNITY/LEGAL HISTORY & FUNCTIONING

Does the child have any current or past involvement with the following?

- Diversion Court No Yes, please explain: _____
- Probation No Yes, please explain: _____
- Arrest No Yes, please explain: _____
- Illegal activity No Yes, please explain: _____
- Juvenile detention No Yes, please explain: _____

Does your child have transportation to and from school, appointments, etc? Yes No – please explain: _____

Does your child have a

- Social Security card? Yes No Driver's license? Yes No

Clinician Comments:

(14) CLIENT/PARENT SIGNATURE

Name of Person completing this form: _____ Relationship to Client: _____

Signature: _____ Date: _____

THIS SECTION IS FOR CLINICIAN USE ONLY. PLEASE DO NOT COMPLETE THIS SECTION.

(15) MENTAL STATUS EXAM

SUICIDALITY/HOMICIDALITY

Client denies any **current** suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Client reports **current** suicidal or homicidal feelings.

Specify: _____

Client denies **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Client has **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Specify: _____

Immediate Therapist intervention needed: _____ (None needed)

MENTAL STATUS

General Behavior: cooperative, passive, withdrawn, dramatic, restless, hostile, anxious, other: _____

Attire: appropriate, seductive, untidy, loud, meticulous, other: _____

Motor Activity: normal, agitated, retarded, tremor, tic, mannerism, other: _____

Productivity of thought: spontaneous, verbose, pressured speech, unproductive, other: _____

Progression of thought: normal, loose, circumstantial, preservation, halting, blocking, incoherent, fragmented, other: _____

Language: normal, baby-talk, peculiar, expression, stilted, other: _____

Mood: indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, normal, composed, anxious, sad, tearful, depressed

Affect: appropriate, inappropriate, other: _____

Perception: normal, auditory hallucination, visual hallucination, illusions, depersonalization, hypochondriasis, other: _____

Orientation: normal, disoriented to time, place, person

Memory: normal, defective (remote, recent, immediate), other: _____

General knowledge: consistent with education, inconsistent, able to abstract, concrete, other: _____

Insight: absent, good, fair, minimal

Judgment: good, fair, poor

(16) CLINICIAN SIGNATURES (The CDA must be signed and dated by all professionals who contribute to its development – PSR staff, etc)

Therapist's Signature Date

Other Date

Client Name: _____

For Medicaid Clients Only
If insurance is not Medicaid please disregard



ICANS Informed Consent

I, _____ (*parent's name*), am the parent or legal guardian of

_____ (*minor client's name*).

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency _____ (*name of provider/agency/organization*) to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164; and the Medicaid Act, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any alcohol or drug abuse patient.

PURPOSES.

I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.

I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

Client Name: _____

EXPIRATION

This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.

I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit determine of eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	Relationship to Client	Date
Full Legal Signature of Parent or Legal Guardian – <i>Required if Client is under 16 years of age, but only after signed by client.</i>	Relationship to Client	Date
Full Legal Signature of Witness (Agency Employee)	Initiating Agency Name	Date