Welcome to Great Plains Mental Health

We are pleased to meet you and honored to be trusted with the care of your child. Our goal is to provide them with the highest quality of care that meets their individual needs. In order to accomplish our goal, we will take time to learn who they are as individuals evaluate all the aspects that impact your child's mental wellbeing. We look forward to working with them.

The mission of Great Plains Mental Health is to approach mental health care from a holistic and integrative model to include all aspects of the human experience to elevate an individual's mental wellbeing. We know to find that place of peace takes more than medication, it takes time and work. Great Plains Mental Health also provides the avenues and space for individuals to do that work offering programs from meditation and yoga to defining your spirituality - GPMH can help you get there.

Scheduled Date of Intake: ___________________

Child's Name: ____

Birth date ____/______/______ Age: ______ Sex: M ____ F _____
Home Address: ____

Home Telephone Number: (____) ____________________________

Person completing this form: _____________________________ Relation to child: _________________

Please Briefly describe your child's problems:

Section I: Demographics

1. Child's Legal Guardian: Name ___________________________ Phone: ____________________

   Relationship to the child: ______________________________ Agency ____________________

2. Mother's Name: ____
   Age: ____ Race: __________________________ Religion: ______________________________
   Marital Status: M____ S _____ D____ Sep___ W____ Adoptive Parent: Yes___ No___
   Occupation: ____________________ Employer: _______________ Work Phone ______________
3. Father's Name: _____________________________________ Phone: _______________________
   Age: ____ Race: _______________ Religion_______________________
   Marital Status: M ____ S ____ D__ Sep ___ W____ Adoptive Parent: Yes ____ No____
   Occupation: ___________ Employer: ____________ Work Phone: ________________
4. Please list all the people living in the home with the child (including non-relatives) and sibling/halfsiblings that may have left the home:

Name	Age	Relationship	Home Status

Section II: Medical/Developmental Information

1. Pediatrician/Family Doctor: ____
2. Pregnancy Birth History:
   a. Mother's age at child's birth: ____ Father's age at child's birth: ______
   b. Please list any medications taken during pregnancy (Other than prenatal vitamins)____
   c. Did the mother drink during the pregnancy? Yes___ No___ How much? _________
   d. Did the mother smoke during the pregnancy? Yes____ No___ How much? ________
   e. Did the other use illicit drugs during the pregnancy? Yes ___ No__ How much? ____
   f. Please Check any of the following that occurred to the mother during the pregnancy

   Excessive Vomiting ___
   Threatened Miscarriage ____
   Toxemia ____
   Infections ___ (specify*)
   Other Illness ___ (Specify*)
   Excessive staining or blood loss ___
   Domestic Violence___
   Premature Labor ___
   Operations (Specify*) ___
   Hospitalization ____

   *____
   ____
   ____

3. Delivery

    Type of labor: Spontaneous ___ Induced ____ Duration of Labor: __________________
    Type of Delivery: Vaginal ____ Breech _____ Cesarean_____
    Complications: ____
    Please specify: ____
    Birth Weight: ________ Lbs. _________Ounces
    Was the baby premature? Yes ______ No _______

4. Infancy: were any of the following a problem for your child after delivery?

    Breathing ____ Infections ____ Needing antibiotic ____
    Heart Problems ___ Needing Oxygen___ Fever___
    Jaundice____ Temperature Control__ Feeding__
    Other ____

5. Did the child have any birth defects? Yes __ No __ (If yes, please specify) _________________
6. How long was the baby in the hospital? ____
7. Was the baby admitted to the ICU? Yes____ No ____ Reason: __________________________
8. Was the child breast fed? Yes ___ No ____ For How Long: ______________________________
9. Developmental Milestones: What age was your child when he/she did the following? (If you cannot recall the age, please check the appropriate column)

	Age	Early	Normal	Late	Not Yet
a. Sate without support	___	___	____	___	____
b. Crawled	____	___	____	___	____
c. Walked without Assistance	____	____	____	___	____
d. Spoken words (beside mama and dad)	___	____	____	___	____
e. Day-time bladder control	____	____	____	____	_____
f. Night-time bladder control	____	____	____	____	_____
g. Day-Time Bladder Control	____	____	____	____	_____
h. Night-time Bowel Control	____	____	____	____	_____
i. Rode a two wheeled bike	____	____	____	____	_____

10. Please describe any other difficulties noted in infancy or toddlerhood ____________________
____
____
____

Present Medical Status

1. Please describe any medical problems your child has (E.G, asthma, diabetes Etc.)
____
____

2. Please list all medications your child is taking

Medication	Dose	Reason Prescribed	Prescribed By	Start Date	Side Effects Reported

3. Please list any allergies including medications and the type of reaction: ______________________
____

4. Has your child had all his/her immunizations? Yes ____ No____
5. Abuse history: To your knowledge, has your child ever been sexually abuse (yes ___ no ___), physically abused (yes __ No ___) neglected (yes ___ no ___) If ss, list when and by whom:

Medical History:

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

1. Please list all childhood diseases your child has had and any complications:

2. Operations and or hospitalizations
   Date _____/______/_______ Hospital_________________ Reason _______________________
   Date _____/______/_______ Hospital_________________ Reason _______________________
   Date _____/______/_______ Hospital_________________ Reason _______________________
3. Head Injuries: Yes ____ No ____
   With loss of consciousness ___ Without loss of consciousness ___
4. Seizures: Yes___ No ____
   With Fever ___ Without Fever __
5. Meningitis: Yes___ No ___ Encephalitis: Yes ___ No ___

School

Please list previous schools, dates attended and indicate overall performance (academic and behavioral)

		Academic	Behavior
(Current School) ____________________	Date ___/____/______	Poor _ Fair _ Good_	Poor_ Fair_ Good_
(Current School) ____________________	Date ___/____/______	Poor _ Fair _ Good_	Poor_ Fair_ Good_
(Current School) ____________________	Date ___/____/______	Poor _ Fair _ Good_	Poor_ Fair_ Good_
(Current School) ____________________	Date ___/____/______	Poor _ Fair _ Good_	Poor_ Fair_ Good_

To the best of your knowledge at what grade is your child functioning

Reading ____ Spelling _____ Math ______

Grades Repeated _____ Grades Skipped _______

Expelled Yes__ No__ How many times? ______ Suspended Yes___ No ____How many times? ________

Present class placement: Regular class ___ Special Class ___ (Please specify) _____________________

Kinds of special therapy or resource assistance your child is receiving: ____________________________

____

____

Describe briefly any problems your child may have with peers: _________________________________

____

____

____

Section III: Mental Health History

1. Does anyone in your family have a history of any of the following?
   a. Depression ___ Who? ___________________________________
   b. Intellectual Disability ___ Who? ___________________________________
   c. Anxiety ___ Who? ___________________________________
   d. Drug/Alcohol Abuse ___ Who? ___________________________________
   e. Suicide ___ Who? ___________________________________
   f. Schizophrenia ___ Who? ___________________________________
   g. Bipolar disorder ___ Who? ___________________________________
   h. Abuse Victim ___ Who? ___________________________________
2. Please describe any major stressors int eh family in the past year. (Separations, moves, deaths, incarcerations, financial, marital)

GREAT ◇ PLAINS
MENTAL HEALTH ASSOCIATES

Child's Name_____________________________

3. Please list all therapist, counselors, psychologist, or psychiatrists the child has seen or is currently seeing. Please include any inpatient hospitalizations, partial hospitalizations or residential facilities.
   Dates (From/To) ____
   Name/Location____
   Reason for Visit: ____
   Helpful Yes___ No ____

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   Dates (From/To) ____
   Name/Location____
   Reason for Visit: ____
   Helpful Yes___ No ____
4. Has your child ever expressed any thoughts of wanting to die or of killing themselves? Yes __ No__
   Did he/she ever make an attempt? Yes ___ No___
5. Has your child ever threatened to kill someone? Yes___ No___ Please describe:
6. Are there any firearms in your home? Yes ___ No ___ If yes, are the firearms locked? Yes___ No ___
   Is the ammunition stored and locked separately? Yes __ No ___

7. Is there anything else you feel we should know about your family?