**KP PANORAMA CITY**

**CHILD/ADOLESCENT INITIAL EVALUATION**

Patient information reviewed and signed which includes confidentiality/exceptions to confidentiality. Informed consent given. Release of information for KP signed. Emergency protocols discussed. KP Behavioral Healthcare Line given 800-900-3277. KP Clinic number given 800-700-8705.

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| **Date:** |  |

**IDENTIFYING DATA:**

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| **Name:** | |  | | | | | | | |
| **Medical Record Number:** | | | | | | | |  | |
| **Birthdate:** | | |  | | | | |
| **Age:** |  | |
| **Sex** (at birth)**:** | | | |  |
| **Ethnicity:** | | |  | | | | | |
| **Emergency Contact:** | | | | | |  | | | | | |
| **Those Attending Session** | | | | | | |  | | | | |
| **Occupation:** | | | | | | | | | | |  |
| **PRESENTING PROBLEM** *(Reason for seeking MH treatment, recent losses/changes/stressors)*: | | | | | | | | | | | | |
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| **Symptoms/Behaviors (frequency, duration)**: |
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| **Onset of Symptoms/Behaviors:** |

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| Sleep Issues (Frequent nightmares/sound /restless sleeper/frequent nightly awakenings/Difficult falling asleep or difficult awakening/shares a room/sleeps in own bed, avg. hrs/night): |

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| **RISK ASSESSMENT:** |
| Self-Harming behaviors: |
| Current Suicidal/Homicidal Ideation, Plan or Intent: |
| History of self-harming behaviors or SI/SA HI/HA: |

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| **Current or History of Traumatic Events:** |

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| **FAMILY COMPOSITION/DYNAMICS**: | | |
| Biological Fathers Name: | Age: | Occupation: |
| Biological Mothers Name: | Age: | Occupation: |
| Living situation (who patient lives with, include siblings/step siblings): | | |
| Family Communication Style: | | |
| Discipline style/strategies: | | |
| Family/Blended family problems: | | |
| Parental quality time w/child: | | |

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| **BEHAVIORAL HEALTH HISTORY** (previous tx, medication hx, psych hospitalizations, addiction treatment): |

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| **FAMILY BEHAVIORAL HEALTH HISTORY:** (mental health disorder, substance use history): |

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| **DEVELOPMENTAL HISTORY:** |
| Developmental problems: |

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| **SOCIAL HISTORY/SUPPORT SYSTEM:** |
| Family of Origin: |
| Relationship History: |
| Children: |
| Social Support |
| IEP'S/SST'S/504 Plan/Tested at school for Learning Disability: |

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| **SOCIALIZATION:** |
| Initiates & sustains friendships easily: |
| Is patient a victim of bullying? |
| Does patient tease or bully others? |
| Sports/Extra-curricular activities: |
| Hobbies/Interests: |

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| **PATIENT MEDICAL HISTORY (**Medical Problems/Chronic Conditions/ Allergies): |

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| **SUBSTANCE USE:** |
| **Alcohol use:**  Amount:  Frequency:  History: |
| **Drug Use:**  Amount:  Frequency:  History: |

**MENTAL STATUS EXAM:**

Apparent age (over/underweight, etc.):

Attire (glasses, braces, etc.):

Grooming:

Hygiene (birthmarks, marks, bruises, etc.):

Eye contact:

Gait and posture:

Behavior / Manner:

Motor activity:

Mood:

Affect:

Speech:

Thought process:

Thought content / perceptual disturbances:

Sensory and cognitive:

Insight:

Judgment:

Reliability:

Impulse:

Other Observations/Additional information:

**DIAGNOSTIC IMPRESSIONS:**

Axis I:

**TREATMENT GOALS:**



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| **TREATMENT PLAN:** |

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| Therapist Signature, License |  | Date |