CHILD STUDY CENTER

New Patient Intake Packet

1210 Wolfe St., Second Floor, Little Rock, Arkansas 72202 · Phone (501) 364-5150 · Fax (501) 364-3966 · www.psychiatry.uams.edu

Mission:

Promote healing in children and families working with emotional and behavioral challenges.

Philosophy:

Build strong relationships with patients and use evidence-based treatments with a multi-disciplinary team approach.

Goal:

Be a model of excellence in providing for the mental health needs of children and their families as well as continue to be a leading center in the training and education of mental health professionals specializing in the care of pediatric populations.

Child and Adolescent Information

Patient's full legal name: _____ Preferred name: _____

Permanent address: _____ City: _____State: ____ Zip:_____

Patient's Social Security Number: _____ Date of Birth: _____ Age: _____

◯ Male ◯ Female Race/Ethnic origin: _____ Religious preference: _____

Legal Guardian's name: _____ Relationship to patient: _____

Permanent Address: _____ City: _____State: ____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Appointment notification method: ◯ Phone ◯ Mail ◯ Text Msg. ◯ Email, address: _____

Legal Guardian's Social Security Number: _____ Date of Birth: _____ Age: _____

If patient is in foster care or DCFS custody:

Caseworker's name: _____ Caseworker's phone number: _____

Parent marital status: ◯ Married ◯ Single ◯ Divorced ◯ Separated

Parent employment status: ◯ Full time ◯ Part time ◯ Retired ◯ Disabled ◯ Self-employed ◯ Student

Number of people living in the home: _____

Person financially responsible or insurance policy holder:

Same as Legal Guardian above? Check if yes _____ If different, fill in next three lines:

1. Name: _____ Relationship to patient: _____
2. Address: _____ City: _____ State: _____
3. Social Security Number: _____ Date of Birth: _____

Insurance information:

Medicaid? ◯ Yes ◯ No Commercial Insurance? ◯ Yes ◯ No

Name of Insurance: _____ Group #: _____

Member/Subscriber ID: _____

Emergency contact (other than the person financially responsible):

Name: _____ Relationship to patient: _____

Home Phone: _____ Cell phone: _____ Work phone: _____

What problem(s) are you seeking help for? _____

_____

_____

_____

What services are you interested in?

○ Medication management ○ Individual therapy ○ Family therapy ○ Testing

Will you be able to attend weekly appointments at this clinic, if this is recommended? ○ Yes ○ No

Types of concerns: What concerns do you have about your child? (Circle all that apply)

Anxiety	Tantrums/anger	Hyperactivity	Sadness/depression	Outbursts
Suicidal thoughts	Irritability	Aggression	Self-injurious behavior	
Defiance	Inattention	Other _____		

Does the child have developmental delays or Autism Spectrum Disorder: ○ Yes ○ No

Trauma, losses, and separations:	Yes	No
Has the child seen any very scary, dangerous or violent situations, or home violence?		
Has the child been abused?		
Has the child been neglected?		
Has child been in foster care?		
Military Deployment of parent?		
Other (death of parent, vehicle accident, natural disaster, etc.)?		

If yes to other, please describe:

_____

_____

_____

Allergies:

○ No known drug allergies ○ Medication allergy; describe: _____

○ Allergies to foods, insects, environmental; describe: _____

Does your child have any physical pain? (Please circle)

None Mild Moderate Severe

Any nutrition problems in the last month? (Please circle any that apply)

Unintended weight loss/gain	Problems chewing/swallowing
Nausea/vomiting	Eating Disorder

Any current health issues? ○ Yes, please describe below ○ No

_____

_____

_____

Past medical and mental health history

Date of last physical exam: _____ Physician's Name: _____

List all past serious injury or illnesses, including head injuries: _____

_____

_____

List past medical and mental health hospitalizations, emergency room visits and outpatient treatment (include reason and date):_____

_____

_____

Does the child use drugs or alcohol? ○ Yes ○ No

Does the child smoke cigarettes or use tobacco products? ○ Yes ○ No

Family history of medical or psychiatric conditions

Relationship	ADD/ADHD	Alcohol Abuse	Anxiety	Bipolar	Cardiac	Dementia	Depression	Diabetes	Drug Abuse	Hypertension	Other addiction i.e. gambling, pornography, etc	Obsessive Compulsive behaviors	Panic Disorder	Paranoid Behavior	Physical Abuse	Schizophrenia	Sexual Abuse	Suicide
Mother																		
Father																		
Sister																		
Brother																		
Maternal Aunt																		
Maternal Uncle																		
Paternal Aunt																		
Paternal Uncle																		
Maternal Grandfather																		
Maternal Grandmother																		
Paternal Grandfather																		
Paternal Grandmother																		

School

What grade is the child in? _____ Name of school: _____

How are grades? ○ Poor ○ Average ○ Good Any learning disabilities? ○ Yes ○ No ○ Unsure

Has the school completed any testing? ○ Yes ○ No If yes, when? _____

Does the child have an IEP or 504 plan? ○ Yes ○ No

Does your child's teacher describe any of the following as significant classroom problems?

	Doesn't sit still in his/her seat		Won't wait his/her turn		Disrespects rights of others
	Frequently gets up & walks around		Doesn't do well in group activities		Doesn't pay attention
	Shouts out		Typically does better one-on-one		Other:

Peer Relations	Yes	No	NA
My child seeks friendships with peers.			
My child is sought by peers for friendship.			
My child plays with children primarily his/her age.			
My child is a leader with peers.			
My child uses good judgement.			

Psychosocial stressors

How hard is it for you to pay for the very basics like food, housing, medical care, and utilities?

Not hard at all Not very hard Somewhat hard Hard Very hard

Within the past 12 months, you worried that your food would run out before you got money to buy more.

Never true Sometimes true Often true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Never true Sometimes true Often true

Within the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

Yes No

Within the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

Yes No

Comments:

_____

_____

_____

Intake Screener

Child's Name: _____ Date of Birth: _____

Please describe the reason you scheduled an appointment with Child Study Center: _____

_____

_____

_____

_____

Is the child receiving mental health services? Yes No

Has the child had testing for (circle all that apply)? Learning Disorder Autism Mental Health Other _____

Has the child been diagnosed with (circle all that apply)? Learning Disorder Autism Mental Health Other _____

Is there any evidence of (circle all that apply)? Learning Disorder Autism Developmental Delay
Please describe:

_____

_____

Please list any medical concerns:

_____

_____

_____

List of current medications	Dose	Prescriber

Directions to Child Study Center

- From I-630, take the MLK Dr. exit and go south (away from the capitol)
- Turn right on 13th St.
- Turn right on Wolfe St.
- Turn left into parking lot for the Clark Center; park in spots marked for patient parking
- Child Study Center is on the second floor

WHAT IS CHADIS?

The UAMS Child and Adolescent Psychiatry Division has partnered with a system called CHADIS (Comprehensive Health and Development Interactive System) which helps us provide your family with the best care possible. CHADIS is a secure, HIPAA-compliant site that allows you to answer many of the questions that we ask during your child's visit in advance of your appointment.

Instructions to register as a New User and complete questionnaire

1. Go to **www.chadis.com** from your smartphone, tablet, or computer.
2. Click on **Register**. Select the button specifying you are a **NEW USER**.
3. Enter our **Invitation Code: 5013645150**
4. Enter your email address and create a password.
   (If you do not have an email address, CHADIS will create a username for you.)
5. Enter your child's information
6. Click **GO** to take questionnaire.
7. On the **Reason for using CHADIS** page, there will be multiple links listed; **please select the link** of the clinic where your appointment is located.
8. Complete questionnaires.
9. Click "Send it, I'm Done" at the end of each questionnaire.

**All answers are completely confidential and are viewed only by our health care staff.*