HealthLinkNow

PATIENT INTAKE-Child/Adolescent

Patient ID #:

Demographics

Race/Ethnicity:

Name:

Phone:

Email:

Identified gender:

Mailing Address:

Preferred language:

Location when participating in sessions:

Current living situation:

DOB:/Age

Pronouns:

Mother's Name:

Father's Name:

Marital Status of Parents:

☐ Single ☐ Married ☐Cohabiting ☐ Divorced ☐ Separated ☐Widowed

Mother's Contact phone number(s): Home_____ Cell Work_____

Father's Contact phone number(s): Home_____ Cell Work_____

If divorced, who has legal custody? Who has physical custody? What is the schedule for parenting time?

_____

_____

How did you hear about HLN: _____

Presenting Problem

What are your current concerns regarding your child? Please list all symptoms and behaviors._____

_____

How long have symptoms and behaviors been present for?_____

Do you have other concerns that you would like addressed?_____

What are your short term goals/expectations for your child's treatment?_____

What are your long term goals/expectations for your child's treatment?_____

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Would you like a referral for support services? Yes ☐ No ☐

If so, what kind of support services?_____

What are your preferences/perceptions of your child's treatment, care, or services?

_____

What mental health services are you seeking from HealthLinkNow? (Check all that apply.) ?

Check all Services you are interested participating in:

- ☐ Psychiatric Medication Management
- ☐ Therapeutic
- ☐ Couples Therapy
- ☐ Group Therapy
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Stress Management
  - ☐ Occupational problems
  - ☐ Anger Management
  - ☐ Past Traumas
  - ☐ LGBTQ+
  - ☐ Self Esteem
  - ☐ COVID-19
  - ☐ Coping Skills

Has your child/adolescent ever HARMED HIM/HERSELF INTENTIONALLY? Yes ☐ No ☐

If yes, please explain: _____

Has your child/adolescent ever ATTEMPTED SUICIDE? Yes ☐ No ☐

If yes, please explain: _____

Has your child/adolescent ever HARMED OTHERS? Yes ☐ No ☐

If yes, please explain: _____

Has your child/adolescent ever been the VICTIM OF ABUSE OR NEGLECT? Yes ☐ No ☐

If yes, what was the nature of the abuse/neglect? _____

Has your child/adolescent experienced a SIGNIFICANT LOSS? Yes ☐ No ☐

If yes, please explain: _____

Has your child/adolescent experienced any PROBLEMS RELATED TO RACE, RELIGION, OR CULTURE?

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Yes ☐ No ☐

If yes, please explain: _____

Has your child/adolescent ever been involved with the following?

Yes ☐ No ☐ Child Protective Services: _____

Yes ☐ No ☐ Probation / Juvenile Probation / Detention / Police:_____

If yes to either, will this be a topic of discussion/influence treatment being sought?

_____

Mental Health History

History of emotional/behavioral functioning:

OUTPATIENT TREATMENT for your child/adolescent (Include current providers if applicable):

Please fill in the table below if applicable:

Provider Type	Name	Location	When (month/year)?	For how long?
Psychiatrist				
Therapist				
Any other provider (e.g. ABA Therapist, etc)				

PSYCHIATRIC HOSPITALIZATIONS for your child/adolescent (residential or day treatment programs, including any alcohol and drug treatment programs):

Where	When (month/year)?	Length of Stay	Type of Treatment	Diagnosis

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CURRENT PSYCHIATRIC MEDICATIONS for your child/adolescent:

Name	Reason (Anxiety, Depression, etc)	Dosage/X's per day	When Prescribed	Prescribed By	Adverse reactions/Side Effect

SUBSTANCE ABUSE HISTORY: *If applicable*

Have you ever smoked cigarettes? Yes☐ No ☐

Currently? Yes☐ No☐

How many packs per day? _____ For how many years?_____

In the past, if quit?_____ For how many years? _____

Do you currently use street drugs or use any prescription drugs not as prescribed? Yes ☐ No ☐

Currently? Yes ☐ No ☐

How many per day? _____ For how many years?_____

In the past, if quit?_____ For how many years? _____

How often have you had a drink containing alcohol in the past year? Consider a drink a bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin or vodka).

☐Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4-5 times/week ☐ 6+ days/week

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Medical History

Patient has executed an Advanced Directive ☐ Yes ☐ No

NUTRITION:

Does your child have any food/medication allergies? ☐ Yes ☐ No

If so, please describe: _____

Has your child lost or gained ten pounds or more in the last 3 months? ☐ Yes ☐ No

What is your current weight? _____

What is your current height? _____

Has your child had a decrease in appetite or amount of food they are eating? ☐ Yes ☐ No

If so, please describe: _____

Does your have any dental problems? ☐ Yes ☐ No

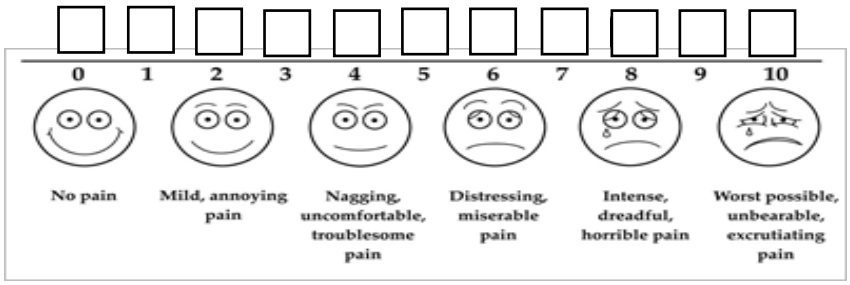
If so, please describe: _____

Does your child have disordered eating habits (example: bingeing, self-induced vomiting)? ☐ Yes ☐ No

If so, please describe: _____

CURRENT PAIN LEVEL:

Is your child in any pain at this time? ☐ Yes ☐ No



Please rate their pain on a scale of 1 through 10, where 10 is the most severe.

Where is your child's pain? _____

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Current medical problems:

_____

_____

Past medical problems, non-psychiatric hospitalizations or surgeries:

_____

_____

For women only: Is your adolescent currently pregnant or do you think they may be pregnant?

☐ Yes ☐ No

Do you have any concerns about your child's physical health that you would like to discuss with us?

☐ Yes ☐ No

Date and place of last physical exam:

_____

Is your child currently prescribed any medical medications (eg., cholesterol, hypertension, etc) ?

☐ Yes ☐ No

If yes, please list below:

Medical Medication/Supplements/OTC	Reason	Dosage	X's/Day (Ie., 2x a day)	Adverse Reaction/Side Effect

_____

_____

_____

If your child's last PCP appointment was longer than 12 months ago or if your child is experiencing medical concerns including those mentioned above, would you like assistance setting up an appt with your PCP:

☐ Yes ☐ No

Are there other physicians/specialists your child sees on a regular basis? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any concerns or have any difficulties paying for your child's prescriptions/medical bills? and or Do you have any concerns with trasportation for your child/adolescent?

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☐ Yes ☐ No If yes, please explain:

_____

_____

Family Mental Health History

Have any of your biological relatives (e.g. parents, grandparents, brothers or sisters, children) had problems with depression, attempted suicide, anxiety, hearing voices, drugs, alcohol, or other mental health problems? And have they been treated by a mental health professional? If yes, list below: ☐ Yes ☐ No

1. Relationship of family member: _____

   Diagnosis or reason for treatment: _____

2. Relationship of family member: _____

   Diagnosis or reason for treatment: _____

3. Relationship of family member: _____

   Diagnosis or reason for treatment: _____

4. Relationship of family member: _____

   Diagnosis or reason for treatment: _____

Social History

Is your child/adolescent your biological child? ☐ Yes ☐ No

If no, at what age was he/she adopted? _____

If adopted, is there any contact with his/her biological parents?

_____

Where was your child/adolescent born and raised?_____

Does your child have any siblings? If so how many and what ages?

_____

Do you have a religious preference in the household? ☐ Yes ☐ No

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If yes, what is that preference?

_____

Do you have an ethnic heritage that is an influence on your child's life? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have a reliable support system he/she can rely on? ☐ Yes ☐ No

Does your child/adolescent have quality relationships with other children/adolescents? ☐ Yes ☐ No

If not, please explain: _____

Has your child/adolescent had a recent change in friendships? ☐ Yes ☐ No

If yes, what changes, if any, are of concern to you?

_____

Does your adolescent have a job? ☐ Yes ☐ No

If yes, explain: _____

What are your child/adolescent's hobbies/interests? _____

_____

Is your child/adolescent able to self care when needed? ☐ Yes ☐ No

If yes explain: _____

Educational History

In what grade level is your child in? _____

What are his/her typical grades? _____

Has there been a change in your child's performance at school? ☐ Yes ☐ No

If yes, please describe: _____

How confident do you feel in your child's ability to succeed at school? _____

Has your child/adolescent ever been held back? ☐ Yes ☐ No

If yes, please describe: _____

Leave this section blank, for HLN office use only:

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INSURANCE INFORMATION

Primary Insurance Name: Member/Subscriber ID:

Name of Policy Holder (first, last):

Relation to Patient (if someone other than patient): Complete below if information is other than patient:
Policy Holder's DOB:

Policy Holder's SSN:

Policy Holder's Email Address:

Policy Holder's Address:

Do you have a secondary insurance? ☐ Yes ☐ No

Complete below if applicable:

Secondary Insurance Name: Member/Subscriber ID:

Name of Policy Holder (first, last):

Relation to Patient (if someone other than patient):

Complete below if information is other than patient

Policy Holder's DOB:

Policy Holder's SSN:

Policy Holder's Email Address:

Policy Holder's Address:

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ADMISSION/INTAKE ASSESSMENT (Part 2)

Columbia- Suicide Severity Rating Scale		
Ask questions that are bolded and underlined. Ask Questions 1 and 2.	**Yes**	**No**
1) Wish to be Dead: **Have you wished you were dead or wished you could go to sleep and not wake up?**	☐	☐
2) Suicidal Thoughts: **Have you actually had any thoughts of killing yourself?**	☐	☐
IF YES to question #2, ask questions 3-6. **If no to question #2,** go directly to question #6.		
3) Suicidal Thoughts with Method: **Have you been thinking about how you might kill yourself?** E.g. "I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it… and I would never go through with it."	☐	☐
4) Suicidal Intent (without specific plan): **Have you had these thoughts and had some intention of acting on them?** As opposed to "I have these thoughts but I definitely will not do anything about them."	☐	☐
5) Suicide Intent with Specific Plan: **Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?**	☐	☐

6) Suicide Behavior Question: **Have you ever done anything, started to do anything, or prepared to do anything to end your life?** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **IF YES, ask: How long ago did you do any of these?**	**Yes: within the past 30 days**	**Yes: over 30 days ago**	**No**
	☐	☐	☐

Low Risk: Schedule initial appointment as soon as possible, notify assigned provider of severity, provider will administer PHQ-9 at initial appointment and document safety planning in session note.

Moderate Risk: Schedule initial appointment as soon as possible, notify assigned provider of severity, provider will administer CSSRS at initial appointment and document safety planning in session note.

High Risk: Evaluate patient for higher level of care. If patient does not meet criteria for higher level of care, complete **Columbia Lifetime Assessment** and designate patient as Moderate Risk and complete moderate risk process.If patient meets criteria for higher level of care, initiate welfare check.

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HealthLinkNow

11249 Gold Country Blvd #130 Gold River, Ca 95670

Patient Identification #:

Patient Health Questionnaire
(PHQ - 9)

Date Completed (mm/dd/yyyy)

☐☐ / ☐☐ / ☐☐☐☐

Time of Administration:

☐ Admission

☐ During Treatment..... { ☐ Days ☐ Weeks ☐ Months } since Admission ☐☐

☐ Discharge

Be sure to fill in all choices with ☒ **not** ☑

Over the last week, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Please place an X in the box below your answer.	0	1	2	3
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
For office coding:	0 +	+	+	

= TOTAL SCORE: ☐☐

(add up each item)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficulty

☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐101

Patient Account Number

■

SAMHSA's 8 dimensions of wellness

Date:

YOUR WELLNESS WHEEL

Score your current level of happiness in each of the sections on this wheel. The scale is 1-5. 1 is your lowest level of happiness and 5 is your highest level of happiness. You can either fill the corresponding section in or you can write some reasons for your score in that section – either way works. Then you can draw lines connecting each section like the example provided by the dotted lines. This is your wheel and it can show you quickly what is working and what still needs improvement. Good luck on your wellness journey.

Key

1. I am very unhappy with this part of my life.

2. I am unhappy with this part of my life, but I haven't hit rock-bottom.

3. This part of my life is pretty good but could still use some improvement.

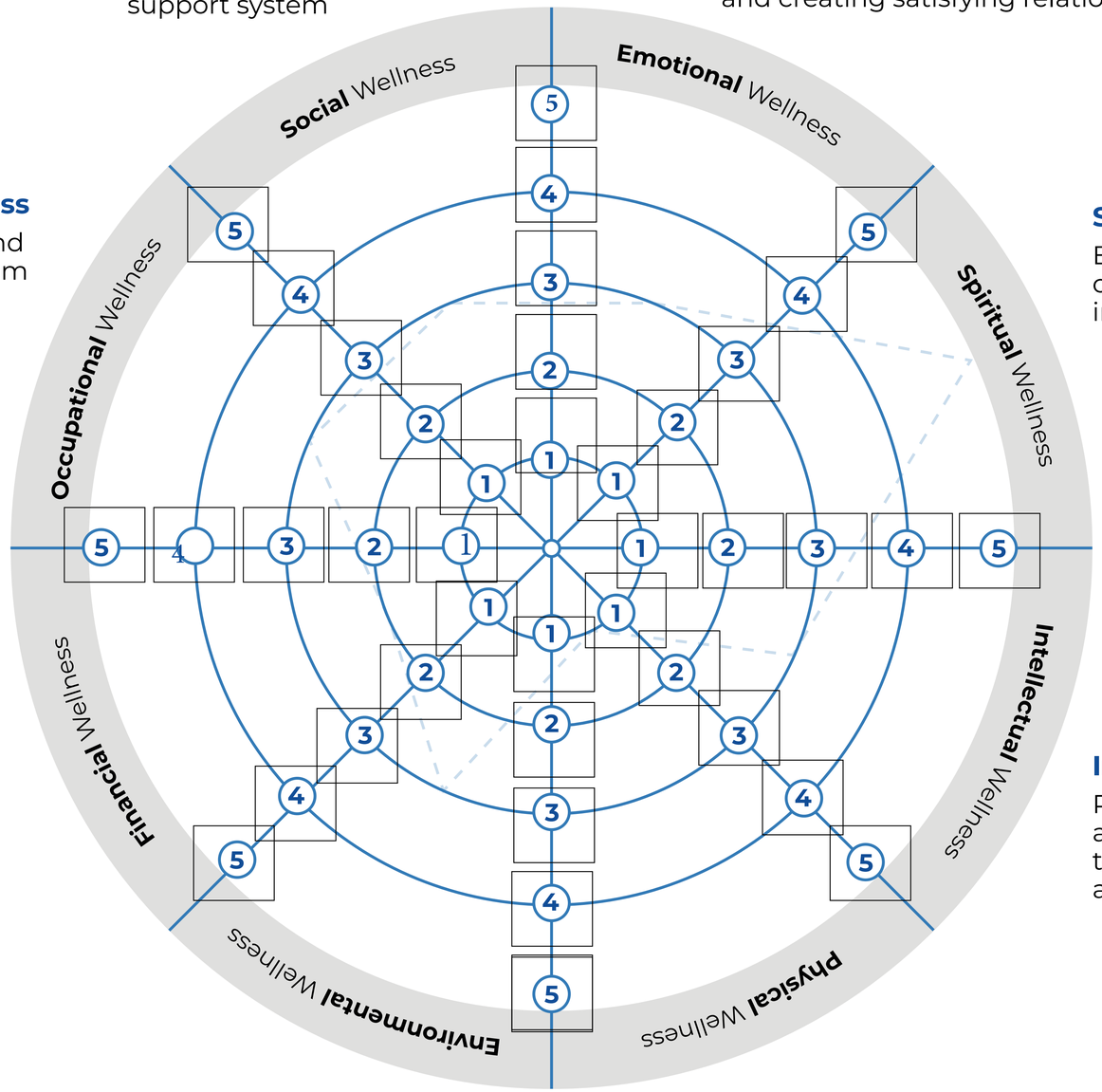
4. I am content with this part of my life, but I can see a few tweaks that would make it even better.

5. I am completely happy and fulfilled in this part of my life – there is no room for improvement.

Social Wellness
Developing a sense of connection, belonging, and a well-developed support system

Emotional Wellness
Coping effectively with life and creating satisfying relationships

Occupational Wellness
Personal satisfaction and enrichment derived from one's work



Spiritual Wellness
Expanding our sense of purpose and meaning in life

Financial Wellness
Satisfaction with current and future financial situations

Intellectual Wellness
Recognizing creative abilities and finding ways to expand knowledge and skills

Environmental Wellness
Good health by occupying pleasant, stimulating environments that support well-being

Physical Wellness
Recognizing the need for physical activity, diet, sleep, and nutrition

*Total will be calculated by administrative team

Total:

HealthLinkNow

Mental Health Resources

If you or someone you know is in need of urgent or in-person mental health services please utilize the following resources:

Emergency Services:

Dial 911 or go to your nearest **Emergency Room**

If the situation is potentially life-threatening, get immediate emergency assistance by calling 911, available 24 hours a day.

National Suicide Prevention Lifeline:

Dial : 988

Trained crisis workers are available to talk **24 hours a day, 7 days a week**. Your confidential and toll-free call goes to the nearest crisis center in the Lifeline national network. These centers provide crisis counseling and mental health referrals.

Find in-person mental health services by visiting:

https://www.findbhhelp.com/