MOUNT SAINT VINCENT
Life Becomes Better

FOR OFFICE USE ONLY

Intake Date: Intake Time:
Program: ☐Residential ☐Day Treatment ☐ANDS ☐ STSU Cottage:
Assigned MSV Therapist: Classroom:

Primary Reason for Referral:
Referral Source:
Referral Contact Name:
Referral Contact Phone:

Funding Source:
Funding Contact Person:
Funding Contact Address:
Funding Contact Phone:
Funding Contact Email:

Anticipated Length of Stay at MSV:
Plan for Parent Involvement:
Permanency/Discharge Plan Goal:
Upon admission, what is the child's diagnosis?

CLIENT REFERRAL INFORMATION

Please fill out as much information as possible and e-mail to Alysha Quinn (aquinn@msvhome.org) prior to your intake appointment.

Child's Full Legal Name: (Please include First, Middle and Last)		Sex: Date of Birth:	☐Male ☐Female
Nickname/Alias:		Social Security Number: Age:	
Child's Address: (address of legal guardian)		Medicaid Number:	
Race: Ethnicity:		Eye Color: Hair Color	
Child's Religion:		Primary Spoken Language: Primary Reading Language:	
Permission to Attend Church While at MSV:	☐ Yes ☐ No		
Placement at Time of Referral :		Placement Contact Person: Placement Contact Phone:	
Who Has Legal Custody of the Child?		Legal Guardian's Relationship to the Child:	
Biological Mother's Name:		Parental Rights:	☐Intact ☐Terminated

Street Address:		No Contact Ordered?	☐ Yes ☐ No
		Phone Number:	
City, State and ZIP Code:		Email Address:	
Biological Father's Name:		Parental Rights:	☐Intact ☐Terminated
Street Address:		No Contact Ordered?	☐ Yes ☐ No
		Phone Number:	
City, State and ZIP Code:		Email Address:	
Parent/Guardian Name: (If different from bio parent)		Relationship to Child:	
Street Address:		Phone Number:	
City, State and ZIP Code:		Email Address:	
Parent/Guardian Name: (If different from bio parent)		Relationship to Child:	
Street Address:		Phone Number:	
City, State and ZIP Code:		Email Address:	

SCHOOL INFORMATION

Who has educational rights of the child?
School district responsible for child's education:
Name and city of most recent school attended:
Grade: Which school year was the child in this grade?
School contact person: Contact phone:
Current **IEP**? ☐ Yes ☐ No Special Education? ☐ Yes ☐ No **IQ** Scores: V P F
Learning difficulties/concentration problems:
Truancy/suspensions/detentions:

LEGAL HISTORY

In the chart below, please note the child's legal history.

Charges	Community service	Arrest/probation

INITIAL ASSESSMENT

Describe the child's strengths:
Describe the child's presenting problems:
Briefly describe proficiency of daily living skills:
Briefly describe difficulties at home and school:
Please list the child's current mental health diagnoses:
Has your child been physically restrained before?
Triggers:
Effective Interventions:

SIGNIFICANT TRAUMA/ABUSE HISTORY

Please identify any past trauma/abuse and elaborate when possible.

- ☐ Physical Abuse:
- ☐ Verbal/ Emotional Abuse:
- ☐ Sexual Abuse:
- ☐ Neglect:
- ☐ Witness to Domestic Violence:
- ☐ Witness to Drug Use/Abuse:

TOPICS OF CONCERN

Please identify topics of concern and elaborate when possible.

- ☐ Aggression (physical):
- ☐ Aggression (emotional and verbal):
- ☐ Agitation:
- ☐ Anger:
- ☐ Anxiety:
- ☐ Argues:
- ☐ Attachment Issues:
- ☐ Blames Others:
- ☐ Compulsions:
- ☐ Cruelty to Animals:
- ☐ Defiant:
- ☐ Depression:
- ☐ Difficulty Focusing:
- ☐ Dissociates:
- ☐ Distractible:
- ☐ Eating Disorder:
- ☐ Encopresis/ Enuresis:
- ☐ Euphoria:
- ☐ Feelings of Hopelessness:
- ☐ Fire Setting:
- ☐ Fluctuating Moods:
- ☐ Foul Language:
- ☐ Grief & Loss:
- ☐ Hallucinations:

- [ ] Homelessness:
- [ ] Homicidal Ideations:
- [ ] Hyperactive:
- [ ] Hypervigilant:
- [ ] Impulsive:
- [ ] Irritable:
- [ ] Lack of Empathy:
- [ ] Little Remorse:
- [ ] Lying:
- [ ] Manipulates:
- [ ] Nightmares:
- [ ] Obsessive:
- [ ] Oppositional:
- [ ] Peer Problems:
- [ ] Poor Self-Esteem:
- [ ] Premature Adolescent Behaviors:
- [ ] Property Destruction:
- [ ] Psychotic Behaviors:
- [ ] Rages:
- [ ] Restless:
- [ ] Runs:
- [ ] Self-Endangering Behavior:
- [ ] Sexual Perpetration:
- [ ] Sexualized Behaviors:
- [ ] Shoplifting:
- [ ] Sleep Difficulties:
- [ ] Stealing:
- [ ] Substance Abuse:
- [ ] Suicidal Attempts:
- [ ] Suicidal Ideation:
- [ ] Suicidal Threats:
- [ ] Temper Tantrums:
- [ ] Undersocialized/ Poor Social Skills:
- [ ] Vision Disability:

DEVELOPMENTAL HISTORY

Pregnancy (unplanned/planned, stressors):
Birth:
Developmental milestones met:
Significant events:

FAMILY INFORMATION

Current living arrangements/family structure:
Family strengths:
Mental health/suicide/significant physical and mental health history within the family:
Substance abuse/use in the family:

CONTACTS/COLLATERALS – Outside Organization Workers:

Please complete and select all boxes that apply.
Please note that:

- Anyone selected as a **"Treatment Team Member"** will participate in forming your child's treatment goals and will participate in staffings, IEP meetings and medication consultations.
- Anyone selected as an **"Incident Notify"** will receive a call within 24 hours of EACH higher level intervention (restraint or locked door quiet room)

Caseworker Name:		Name of Organization:	
Street Address (Mailing):		Email Address:	
City, State and ZIP Code:		Office Phone: Mobile Phone:	
Emergency Contact:	☐ Yes ☐ No	Treatment Team Member:	☐ Yes ☐ No
Incident Notify:	☐ Yes ☐ No	LAN?:	☐ Yes ☐ No
Eligible Visitor:	☐ Yes ☐ No	Visitation Allowed:	☐ Off Campus ☐ On Campus
Can Pick Up Child:	☐ Yes ☐ No	Pass Allowed:	☐ Day Pass ☐ Overnight Pass
Calls to the Child Allowed:	☐ Yes ☐ No	Calls from the Child Allowed:	☐ Yes ☐ No

GAL Name:		Email Address:	
Street Address (Mailing) :		Office Phone: Mobile Phone:	
City, State and ZIP Code:			
Emergency Contact:	☐ Yes ☐ No	Treatment Team Member:	☐ Yes ☐ No
Incident Notify:	☐ Yes ☐ No	LAN?	☐ Yes ☐ No
Eligible Visitor:	☐ Yes ☐ No	Visitation Allowed:	☐ Off Campus ☐ On Campus
Can Pick Up Child:	☐ Yes ☐ No	Pass Allowed:	☐ Day Pass ☐ Overnight Pass
Calls to the Child Allowed:	☐ Yes ☐ No	Calls from the Child Allowed:	☐ Yes ☐ No

CASA Name:		Email Address:	

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Street Address (Mailing):		Office Phone: Mobile Phone:	
City, State and ZIP Code:			
Emergency Contact:	☐ Yes ☐ No	Treatment Team Member:	☐ Yes ☐ No
Incident Notify:	☐ Yes ☐ No	LAN?	☐ Yes ☐ No
Eligible Visitor:	☐ Yes ☐ No	Visitation Allowed:	☐ Off Campus ☐ On Campus
Can Pick Up Child: Calls to the Child Allowed:	☐ Yes ☐ No ☐ Yes ☐ No	Pass Allowed: Calls from the Child Allowed:	☐ Day Pass ☐ Overnight Pass ☐ Yes ☐ No
Name (Other Outside Worker):		Name of Organization:	
Street Address (Mailing):		Email Address:	
City, State and ZIP Code:		Office Phone: Mobile Phone:	
Emergency Contact:	☐ Yes ☐ No	Treatment Team Member:	☐ Yes ☐ No
Incident Notify:	☐ Yes ☐ No	LAN?	☐ Yes ☐ No
Eligible Visitor:	☐ Yes ☐ No	Visitation Allowed:	☐ Off Campus ☐ On Campus
Can Pick up Child: Calls to the Child Allowed:	☐ Yes ☐ No ☐ Yes ☐ No	Pass Allowed: Calls from the Child Allowed:	☐ Day Pass ☐ Overnight Pass ☐ Yes ☐ No

CONTACTS/COLLATERALS – Family, friends and other contacts:

Please complete and select all boxes that apply.
Please note that:

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- Anyone selected as a **"Treatment Team Member"** will participate in forming your child's treatment goals and will participate in staffings, IEP meetings and medication consultations.
- Anyone selected as an **"Incident Notify"** will receive a call within 24 hours of EACH higher level intervention (restraint or locked door quiet room)
- A phone call is **"Monitored"** when staff is nearby and listens to the child's half of the phone conversation (the phone is not on speaker).
- A phone call is **"Supervised"** when staff sits with the child, the phone is on speaker and staff listens to the entire conversation.
- A visit is **"Monitored"** when the visit occurs nearby and the staff checks in on the child and visitors from time to time (staff are not directly involved with the visit).
- A visit is **"Supervised"** when staff sits with the child and visitors and listens to/observes the entire visit.

Name:		Relationship to Child:	
Street Address (Mailing):		Phone Number (day): Phone Number (evening): Phone Number (mobile):	
City, State and ZIP Code:		Email Address:	
Emergency Contact:	☐ Yes ☐ No	Treatment Team Member:	☐ Yes ☐ No
No Contact Ordered:	☐ Yes ☐ No	Incident Notify:	☐ Yes ☐ No ☐ Yes ☐ No
Eligible Visitor:	☐ Yes ☐ No	Visitation Allowed:	☐ Off Campus ☐ On Campus
Visits Monitored:	☐ Yes ☐ No	Visits Supervised:	☐ Yes ☐ No
Can Pick Up Client:	☐ Yes ☐ No	Type of Pass Allowed:	☐ Day Pass ☐ Overnight Pass
Calls to the Child Allowed:	☐ Yes ☐ No	Calls From the Child Allowed:	☐ Yes ☐ No
Calls Monitored:	☐ Yes ☐ No	Calls Supervised:	☐ Yes ☐ No

Name:		Relationship to Child:	
Street Address (Mailing):		Phone Number (day): Phone Number (evening): Phone Number (mobile):	
City, State and ZIP Code:		Email Address:	
Emergency Contact:	☐ Yes ☐ No	Treatment Team Member:	☐ Yes ☐ No
No Contact Ordered:	☐ Yes ☐ No	Incident Notify:	☐ Yes ☐ No ☐ Yes ☐ No
Eligible Visitor:	☐ Yes ☐ No	Visitation Allowed:	☐ Off Campus ☐ On Campus
Visits Monitored:	☐ Yes ☐ No	Visits Supervised:	☐ Yes ☐ No
Can Pick Up Client:	☐ Yes ☐ No	Type/s of Pass Allowed:	☐ Day Pass ☐ Overnight Pass
Calls to the Child Allowed:	☐ Yes ☐ No	Calls From the Child Allowed:	☐ Yes ☐ No
Calls Monitored:	☐ Yes ☐ No	Calls Supervised:	☐ Yes ☐ No

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City, State and ZIP Code:		Email Address:	
Emergency Contact:	☐ Yes ☐ No	Treatment Team Member:	☐ Yes ☐ No
No Contact Ordered:	☐ Yes ☐ No	Incident Notify:	☐ Yes ☐ No ☐ Yes ☐ No
Eligible Visitor:	☐ Yes ☐ No	Visitation Allowed:	☐ Off Campus ☐ On Campus
Visits Monitored:	☐ Yes ☐ No	Visits Supervised:	☐ Yes ☐ No
Can Transport Client:	☐ Yes ☐ No	Type/s of Pass Allowed:	☐ Day Pass ☐ Overnight Pass
Calls to the Child Allowed:	☐ Yes ☐ No	Calls From the Child Allowed:	☐ Yes ☐ No
Calls Monitored:	☐ Yes ☐ No	Calls Supervised:	☐ Yes ☐ No
Name:		Relationship to Child:	
Street Address (Mailing):		Phone Number (day): Phone Number (evening): Phone Number (mobile):	
City, State and ZIP Code:		Email Address:	
Emergency Contact:	☐ Yes ☐ No	Treatment Team Member:	☐ Yes ☐ No ☐ Yes ☐ No
No Contact Ordered:	☐ Yes ☐ No	Incident Notify:	☐ Yes ☐ No
Eligible Visitor:	☐ Yes ☐ No	Visitation Allowed:	☐ Off Campus ☐ On Campus
Visits Monitored:	☐ Yes ☐ No	Visits Supervised:	☐ Yes ☐ No
Can Pick Up Client:	☐ Yes ☐ No	Type/s of Pass Allowed:	☐ Day Pass ☐ Overnight Pass
Calls Allowed to Child:	☐ Yes ☐ No	Calls Allowed From Child:	☐ Yes ☐ No
Calls Monitored:	☐ Yes ☐ No	Calls Supervised:	☐ Yes ☐ No

TREATMENT HISTORY

In the chart below, please note the child's placement history. Include foster and adoptive placements, residential treatment, day treatment and hospitalizations.

Type of placement	Name of facility	Dates	Reason for placement

In the chart below, please note the child's mental health outpatient services. Include individual therapy, group therapy, family therapy, psychiatric treatment, psychiatric evaluations and mental health evaluations.

Type of service	Name of service provider	Dates

MEDICAL / HEALTH HISTORY

Who has medical rights of the child?
Psychiatrist's name and phone number:
Medication compliance:
Allergies:
Chronic illnesses:
Hospitalizations unrelated to mental health/severe behaviors:
Other significant medical issues:
Past mental health diagnoses:

In the chart below, please all PAST medications tried and their side effects.

Medication	Date tried	Side effects

In the chart below, please list all of the child's CURRENT medications.

Medication	Dosage	Time