

Stress, Trauma & Adversity Research and Treatment



Department of Psychiatry

SCHOOL OF MEDICINE

UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

START Center Clinic - Outpatient Child/Adolescent Intake Form

Date: _____

Client's Legal Name: _____

Preferred Name (if different from above): _____ Age: _____

Parent/Guardian 1's Name: _____

Parent/Guardian 2's Name: _____

Address: _____

Client's Cell Phone: _____

Client's E-mail: _____

Home Phone 1: _____

Home Phone 2: _____

Parent/Guardian 1's Cell Phone: _____

Parent/Guardian 2's Cell Phone: _____

Parent/Guardian 1's E-mail: _____

Parent/Guardian 2's E-mail: _____

The information you give us will help us determine the best way for us to support your child. Please note the following as you fill out the packet:

- 1) If your child is in immediate danger, please go to the nearest ER or call 911.
- 2) Your intake provider will send a letter to your regular doctor with the diagnostic impressions and treatment recommendations.

_____ initial here if you **DON'T** want us to send the information to your regular doctor.

CONSENT TO BE CONTACTED FOR RESEARCH

It is part of the START Center's mission to support research to provide the best treatment possible for children. We are currently conducting several research studies. You may want to take part in one of the research studies. Whether you participate will not make any difference in your treatment. Please check one of the answers below to indicate if you want to hear about relevant research studies. If you have any questions about our research studies, please ask your mental health provider.

If you choose to be contacted for research, this **does not mean that you have assented to participate**, only to hear the options. You can't be enrolled in research without your parent/guardian's explicit, written consent.

___ **I assent to be contacted by a member of the research team**

___ **I have read this form and I DO NOT wish to be contacted for research**

Child's Signature

Date

I. Demographic Information:

Race (please check all that apply):

- American Indian or Alaska Native Asian
- Native Hawaiian or Other Pacific Islander White
- Black or African American Additional not listed: _____
- Multiracial (please describe): _____

Ethnicity: _____

Are you of Hispanic origin? Yes No

Please describe how you identify your race/ethnicity: _____

Sex assigned at birth: Male Female Intersex Unassigned

Gender (check all that apply): Man Woman Transgender Non-binary

Agender Additional not listed: _____

Which pronouns do you use: _____

Sexual Orientation: Heterosexual Bisexual Gay Lesbian

Asexual Queer Pansexual Questioning Additional not listed: _____

Do you have additional comments regarding your responses above?

If not completed by parent/guardian:

Please describe the people living in your home and how you know them:

	Gender	Age	Marital Status [S ingle (never married) M arried D ivorced, W idowed I n a relationship C ohabiting]	Relationship to you						
Name: <input type="checkbox"/> Lives in home			<table style="margin: auto; border: none;"> <tr> <td>S</td> <td>M</td> <td>D</td> </tr> <tr> <td>In</td> <td>W</td> <td>Co</td> </tr> </table>	S	M	D	In	W	Co	Parent: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster Sibling: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster Other (e.g., uncle, cousin, family friend): _____
S	M	D								
In	W	Co								
Name: <input type="checkbox"/> Lives in home			<table style="margin: auto; border: none;"> <tr> <td>S</td> <td>M</td> <td>D</td> </tr> <tr> <td>In</td> <td>W</td> <td>Co</td> </tr> </table>	S	M	D	In	W	Co	Parent: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster Sibling: <input type="checkbox"/> Bio <input type="checkbox"/> Step <input type="checkbox"/> Half <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster Other (e.g., uncle, cousin, family friend):
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S	M	D								
In	W	Co								

<input type="checkbox"/> Lives in home				<input type="checkbox"/> Adoptive <input type="checkbox"/> Foster Other (e.g., uncle, cousin, family friend):
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Is there any additional information you would like us to know about your family or your family structure (for example, does your child live in multiple homes, if yes, how many and what are the relationships)?

II. Social History

Are you currently in school? Yes No

What grade are you in? _____

If you are currently in school

Name of current school: _____

Primary School Point of Contact (e.g., Teacher): _____ Grade: _____

Type of school: Public _____ Private _____ Other (home, online, therapeutic, etc.) _____

What kind of grades, on average, are you getting (for example GPA)? _____

What are your favorite subjects? _____ What are your least favorite subjects? _____

Are you involved in any extracurricular activities (e.g., sports, clubs)? If yes, please describe.

Are you currently having any difficulties in school? If yes, please describe.

Are you receiving any support for these difficulties? If yes, please describe.

Do you often get in trouble at school (e.g., detention, missing multiple days)? If yes, please describe.

Do you currently have a job or volunteer? Yes No

If yes, what is your current job or volunteer work? _____

If applicable, what jobs have you had in the past? _____

Have you had any legal issues (arrests, charges, time in jail)? Please describe:

Are you currently or have you ever been homeless? Yes, currently Yes, previously No, never

If over 12 years old:

Do you have children? Yes No If yes, how many & what are their ages? _____

III. Medical History

Do you have a primary care doctor/pediatrician?

Yes Do not currently have a primary care doctor/pediatrician

If yes

Name: _____

Name of practice: _____

Last Seen: _____

Please list any medical conditions:

Please describe any prior surgeries: _____

Medications you are currently taking, including prescribed, over-the-counter medications, herbals, and supplements:

Medication	Dosage	For what condition	Who prescribes it (if applicable)

Describe any allergies you have (medications, foods, etc.): _____

Are all immunizations up to date? Yes No Don't know

Are you experiencing any of these physical symptoms, currently or recently?

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Headache | <input type="checkbox"/> Pain or difficulty urinating |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hot/cold flashes |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Decreased sex drive |
| <input type="checkbox"/> Unexplained weight loss/gain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Problems reaching orgasm |
| <input type="checkbox"/> Weakness in arms/legs | <input type="checkbox"/> Cough | <input type="checkbox"/> Easy bruising or bleeding |
| <input type="checkbox"/> Numbness in arms/legs | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Episodes of passing out | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Problems walking | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Changes in vision |
| <input type="checkbox"/> Joint pains | <input type="checkbox"/> Constipation | <input type="checkbox"/> Changes in hearing |
| <input type="checkbox"/> Muscle pains or tension | <input type="checkbox"/> Acid reflux | |

Have you ever received a mental health diagnosis or mental health treatment? For instance, being seen by a psychiatrist, neurologist, psychologist, counselor, or therapist? Please list and describe:

Date(s) (if known)	Mental Health Condition (e.g., PTSD, depression, bipolar, schizophrenia, ADHD) [if known]	Medical Provider who gave the Diagnosis (e.g., Psychiatrist, Counselor, Psychologist, Social Worker) [if known]	If known, what treatment did you receive (medications, ECT, psychotherapy)?

Have you ever been hospitalized for mental health concerns? Please list and describe:

Date(s)	Where were you hospitalized?	For what reason?	If known, what treatment (medications, ECT, psychotherapy)?

Have you ever used:

	If yes, which	Last time used	#times per week	#times per month	#times per year
Alcohol <input type="checkbox"/> N/A					
Caffeine <input type="checkbox"/> N/A					

Cocaine/Crack <input type="checkbox"/> N/A					
Inhalants (nitrous oxide) <input type="checkbox"/> N/A					
Hallucinogens (MDMA/ecstasy, mushrooms) <input type="checkbox"/> N/A					
Marijuana/THC (ingesting, smoking, vaping) <input type="checkbox"/> N/A					
Opiates (Percocet, heroin, morphine, etc.) <input type="checkbox"/> N/A					
Recreational use of prescription medication (Adderall) <input type="checkbox"/> N/A					
Stimulants (methamphetamines) <input type="checkbox"/> N/A					
Tobacco/nicotine (chewing, smoking, vaping) <input type="checkbox"/> N/A					
Others? (please list) _____ _____					

Sexual Health (skip if not relevant to you):

Are you sexually active? Yes No

If yes:

Do you use any birth control? Yes No If yes, please describe: _____

Describe any safe sex practices that you use: _____

If applicable

Last menstrual period: _____ (N/A)

Are you cycles regular: Yes No

Have you been pregnant before? Yes No

If yes, how many times: _____

Please describe any distress you had before, during, or following your pregnancy?

Have you experienced pregnancy loss? Yes No Have you terminated a pregnancy? Yes No

Genetic factors can also contribute to illnesses. Because of this, providing additional information regarding illnesses of biological relatives can be helpful. Please complete this to the best of your ability:

	Sibling	Parent 1 <input type="checkbox"/> Biological	Parent 2 <input type="checkbox"/> Biological	Parent 1's side <input type="checkbox"/> Biological	Parent 2's side <input type="checkbox"/> Biological
Alcohol misuse					
Anxiety disorders					
Attention-Deficit/Hyperactivity Disorder					
Bipolar disorder					
Cancer					
Depression					

Diabetes					
Substance use					
Heart disease/high blood pressure/ arrhythmias					
Osteoporosis					
Seizures					
Schizophrenia					
Stroke					
Suicide					
Thyroid disease					

IV. Coping Skills

Who are the important people in your life? _____

What do you do in your free time?

Do you exercise? Yes No

If yes, how often and for how long (e.g., 2 x week; 45 min): _____

Do you have any spiritual or religious practices? Yes No

If yes, how would you identify your spiritual or religious beliefs (ex. Christian, Jewish, Muslim):

How important are your religious/spiritual beliefs to you? _____

How important are your religious/spiritual beliefs to your family? _____

When you need to talk to someone, who do you talk to for advice and support?

Are there certain communities that you are a part of that are important to you (e.g., sports teams, church groups, etc.)? If yes, please describe.

V. Today's Visit

Who were you referred by:

Self Other: _____

Why were you referred:

What concern(s) bring(s) you to our clinic today?

What stressors are impacting your family as of late (e.g. Family, job, recent loss of loved ones, issues at school, moving)?

Any new changes in your family or home?

Signature of parent or caregiver

Date

Signature of Reviewing Clinician

Date

-Administration of Standard Intake Measures

-Please consult the Provider Screening Form as Appropriate (e.g., Columbia for PHQ-9 item 9; AUDIT for alcohol misuse screen, resources for current violence/homelessness)