ORCHARD PLACE CAMPUS ACCESS FORM

Please complete the following information to the best of your ability. This information is critical to the treatment that your child and family will receive. Full and accurate information is necessary. Please return this form to the Orchard Place admissions personnel at
925 SW Porter Ave, Des Moines, IA 50315 or Fax to 515-287-9695

Date Request Made: _____

Person Filling Out Form and Relationship to Child: _____

SECTION 1 - CHILD'S DEMOGRAPHIC INFORMATION

Full Name (First, Middle, Last): _____

Preferred Name/Nickname: _____

SSN #: _____ Date of Birth: _____ Age: _____

City/State Born in: _____ Religious Preference: _____

Identified Gender: ☐ Female ☐ Male ☐ Other/Non-Binary Sex Assigned at Birth: ☐ Female ☐ Male

Preferred Pronouns: _____

CHILD's LEGAL HISTORY *(Check all that apply)*

☐ CINA ☐ Consent Decree ☐ Formal Probation ☐ Delinquent

☐ Informal Probation ☐ Other Police Involvement ☐ No Legal Involvement ☐ Unknown

☐ DHS Involvement If DHS involvement, please explain: _____

Is Child under Court Order? ☐ Yes ☐ No Date of Adjudication: _____

CLIENT RACE / ETHNICITY *(As identified by the client)*

RACE:

☐ **White/Caucasian:** A person having origins in any of the original people of Europe, Middle East, or North Africa.
☐ **Black/African American:** A person having origins in any of the racial groups of Africa.
☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent. (Cambodia, China, Indian, Japan, Korea, Laotian, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam)
☐ **Native/Latin American or Alaska Native:** A person having origins in any of original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
☐ **Native Hawaiian/Pacific Islander:** A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ **Multi-Racial:** A person having more than one of the race's listed above.

ETHNICITY:

☐ **Hispanic:** Yes, Hispanic, Latino, Spanish, Mexican, Puerto Rican, or Cuban Origin
☐ **Non-Hispanic:** No, not of Hispanic, Latino, Spanish, Mexican, Puerto Rican, or Cuban Origin

CULTURAL NEEDS: Is there anything we need to consider to meet you/your child's cultural needs? For example: Hair care products, hygiene products, holidays, roommate considerations, therapist considerations, language, etc.

SECTION 2 - SERVICES PROVIDERS/SUPPORTS

Indicate all services child is currently receiving or has received in the past year.

Provider Name/Agency/Address/Phone Number/Fax Number

Attorney _____

BHIS _____

Court Based Intervention _____

Day Treatment/Partial Hospitalization _____

DHS Worker _____

Detention _____

Early Service Project _____

Foster Care _____

Integrated Health Program _____

Guardian Ad Litem _____

Inpatient Hospitalization(s) _____

IQ Testing _____

Juvenile Court Officer (JCO) or Probation Officer _____

Juvenile Court School Liaison _____

Medication Management _____

PMIC(s) _____

Primary Care Physician (PCP) _____

Psychiatrist/Medication Manager _____

Psychological Testing_____

Residential Treatment _____

Shelter(s) _____

Substance Abuse _____

Tracker _____

Therapy _____

Other Providers _____

SECTION 3 – FAMILY INFORMATION

Legal Custodian of Child: _____

Who Does Child Normally Live With: _____

Where is Child Living Now: _____

If Out of Home, List Date Placed at This Location: _____ Last Date Child Lived at Home: _____

Custody/Visitation Info:

_____

Parent/Guardian

Name: _____

Step-parent: _____

Address: _____

_____
(if different from the child)

Telephone: Home #: _____

Highest Level of Education: _____

Occupation: _____

Work #: _____

Can we contact you at work? ☐ Yes ☐ No

Cell #: _____

Email Address: _____

Date of Birth: _____

Parent/Guardian

Name: _____

Step-parent: _____

Address: _____

_____
(if different from the child)

Telephone: Home #: _____

Highest Level of Education: _____

Occupation: _____

Work #: _____

Can we contact you at work? ☐ Yes ☐ No

Cell #: _____

Email Address: _____

Date of Birth: _____

Military History / Service Record of the Parents: _____

Are There Other Caretakers for the Child: _____

Sibling Information

Sibling's Names (First and Last)	Live in Home? Y/N	Gender (F)emale (M)ale (O)ther	Date of Birth/Remarks
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____
_____	☐ / ☐	☐ F ☐ M ☐ O	_____

Others in the Home

_____	☐ F ☐ M ☐ O	_____
_____	☐ F ☐ M ☐ O	_____
_____	☐ F ☐ M ☐ O	_____

Is your child adopted? ☐ Yes ☐ No If Yes, at what age? _____

List important information about the birth family:

_____

Who in the child's/family's life is the child close to?

_____

Family Stressors and Mental Health History: *(select all the apply)*

☐ Abandonment
☐ Abuse
☐ Child abuse investigation current or previous
☐ Child custody/visitation dispute
☐ Citizenship
☐ Court involvement
☐ DHS involvement
☐ Death
☐ Disability
☐ Domestic violence
☐ Educational
☐ Employment
☐ Financial
☐ Illness
☐ Incarceration
☐ Mental health disorder
☐ Neighborhood
☐ Numerous moves
☐ Physical Illness
☐ Separation/divorce
☐ Sibling rivalry/conflict
☐ Substance abuse
☐ Suicides attempts in the family
☐ Suicide completions in the family
☐ Transportation
☐ Other *(explain below)*

Describe Other Family Stressors or Mental Health History:

For each item identified, please describe:

If abuse, abuse investigation, suicide attempts or completions or family mental health issues, please indicate who and their relationship to the child.

SECTION 4 – DEVELOPMENTAL HISTORY

Prenatal Care (include feelings regarding pregnancy, mother's age, number of pregnancies, planned pregnancy, regular check- ups/prenatal care, other supports):

Complications during Pregnancy (include domestic violence/abuse, involved in accident, serious/viral illness):

Substance Used and/or Medications Prescribed During the Pregnancy: ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes: (*select all that apply)*

- ☐ Alcohol
- ☐ Cigarettes
- ☐ Prescription Drugs
- ☐ Street Drugs

Description of Substance Type and Frequency of Use:

Term and Delivery: *(Select appropriate)*

- ☐ C-Section
- ☐ Full Term
- ☐ Normal Delivery
- ☐ Premature
- ☐ Unknown

Complications During and/or Following Labor/Delivery (include anesthetic/medication(s) used, emotions of parents surrounding delivery, medical problems, oxygen used for baby following delivery, seizures):

Birth Weight: _____

Infant/Early Childhood Temperament: *(check all that apply)*

- ☐ Cuddly
- ☐ Easy to Comfort
- ☐ Irritable
- ☐Overactive
- ☐ Quiet/Aloof
- ☐Other (explain below)
- ☐ Unknown

_____

Description of Infant/Early Childhood Temperament:

Developmental Milestones

Sitting At (Months):_____ Crawling At (Months):_____ Walking At: _____

Saying Words At (Months): _____ Saying Sentences (Months): _____ Toilet Trained: _____

Developmental Concerns: *(Select all that apply)*

- ☐ Difficulty Separating from Parent
- ☐ Indiscriminate Interactions
- ☐ Speech Problems
- ☐ Suspicion of Autism
- ☐ Suspicion of Intellectual Disability
- ☐ Slower Development than Other Children
- ☐ Other (explain below) _____

Description of Developmental Milestones and/or Concerns (include if child nursed, used a pacifier, eating, fine/gross motor skills, hearing, how and where child sleeps):

SECTION 5 - TRAUMA HISTORY

History of Trauma: *(select all that apply and then describe below)*

- ☐ Accidents, e.g., care accidents
- ☐ Assault
- ☐ Attacked by an animal
- ☐ Care provider mental illness
- ☐ Community violence
- ☐ Contact with a sexual offender
- ☐ Death of someone important to child
- ☐ Domestic violence
- ☐ Emotional abuse
- ☐ Exploitation
- ☐ Illness
- ☐ Incarceration
- ☐ Mental health discrimination
- ☐ Natural disasters
- ☐ Physical abuse
- ☐ Physical abuser
- ☐ Racial language
- ☐ Racial trauma
- ☐ Rape
- ☐ Separation from caregiver/parent
- ☐ Sexual abuse - victim
- ☐ Sexual abuse - perpetrator
- ☐ Sexually Inappropriate with someone else
- ☐ Social trauma
- ☐ Suicide/ attempts
- ☐ Verbally abused, e.g., name calling, etc
- ☐ Witness to physical or sexual abuse
- ☐ Other (explain below)

Description of Trauma History and concerns *(please include age(s) of those involved)*:

If child has any physical, or sexual abuse, please indicate by whom abuse occurred.

If the child has contact with a person who is a sex offender please list person name.

SECTION 6 - REFERRAL INFORMATION/PRESENTING CONCERNS

Who is recommending Orchard Place Campus for your child?

_____

Reason for Referral: *(Select all that apply)*

- ☐ Addictive behaviors
- ☐ Aggression toward others
- ☐ Aggression with property
- ☐ Attempts to kill self
- ☐ Attempts to kill others
- ☐ Bouts of severe anxiety/panics
- ☐ Confused/inflexible thinking
- ☐ Confusion of fantasy and reality
- ☐ Cussing
- ☐ Depressive statements
- ☐ Disorientated
- ☐ Easily distracted
- ☐ Easily frustrated
- ☐ Fire-setting
- ☐ Hearing voices or seeing vision
- ☐ Hurts animals or others
- ☐ Hyperactive
- ☐ Impulsive
- ☐ Inability to plan, organize, or sequence
- ☐ Inattentive
- ☐ Irritability/temper
- ☐ Language/speech problems
- ☐ Lying (other than minor ones)
- ☐ Outbursts
- ☐ Paranoid or unusual fears
- ☐ Picking at sores
- ☐ Plays with objects unusually
- ☐ Problem with authority
- ☐ Pulling out eyelashes
- ☐ Refuses to follow directions
- ☐ Repetitive behaviors
- ☐ Rocking/banging
- ☐ Running away
- ☐ Self-injury
- ☐ Short or long term memory problems
- ☐ Stealing
- ☐ Talks to self
- ☐ Throwing things
- ☐ Unusual thinking, e.g., odd or off-the-wall ideas
- ☐ Yelling
- ☐ Other *(explain below)*

_____

Description of Behavioral History and Concerns:

SECTION 7 - MEDICATIONS, DIAGNOSIS, AND USE OF HISTORY OF RESTRAINT OR SECLUSION

Please list your child's **current** psychiatric diagnosis:

_____

Please list your child's **previous** psychiatric diagnosis:

_____

Is child **currently** taking psychiatric medications? ☐ Yes ☐ No

List current psychiatric medication and response to the medication:

_____

Has your child taken psychiatric medications **previously**? ☐ Yes ☐ No

If **yes**, list previous psychiatric medication, response to the medication and reason for discontinuing:

_____

Has your child ever been restrained in a hospital, in a crisis stabilization unit, school at home or other setting?

☐ Yes ☐ No

If **yes**, indicate when, why and child's response.

_____

Are you aware of any medical conditions or any physical disabilities that may cause problems during a physical restraint

_____

Are there any nutritional concerns? If yes, please explain below: ☐ Yes ☐ No

_____

SECTION 8 - LIFE SKILLS AND BEHAVIORAL INFORMATION

Check all daily living activities your child can perform independently.

- ☐ Bathing
- ☐ Brushing Teeth
- ☐ Cleaning
- ☐ Cooking Simple Meals
- ☐ Doing Laundry
- ☐ Dressing Appropriately
- ☐ Driving
- ☐ Grooming Self
- ☐ Managing Medications
- ☐ Using the Phone
- ☐ Waking up on Own
- ☐ Washing Hair
- ☐ Other

Please list any concerns you have about your child's life skills or skills your child needs assistance with:

Any concerns with wetting or soiling self either during the day or at night? ☐ Yes ☐ No If **yes**, please describe:

Social/Recreational History

Relationship with Peers: *(Select all that apply)*

- ☐ Age-Appropriate Social Skills
- ☐ Fights
- ☐ Leader
- ☐ Poor Boundaries
- ☐ Bossy
- ☐ Follower
- ☐ Misuse of Social Media
- ☐ Problems with Peers
- ☐ Bullying
- ☐ Gang Involvement
- ☐ Outgoing
- ☐ Withdrawn
- ☐ Other (explain below)

Description of Relationship with Peers:

Interests/ Extracurricular Activities:

Any history that would indicate child needs a single room such as: sexual behavior, aggression, socialization issues?
(please note children needing single rooms may have to wait longer to be admitted)

What are the rules and consequences in your home?

Other concerns or comments?

SECTION 9 - SEXUAL INFORMATION/HISTORY

Check all that apply and then describe below.

☐ Begun Dating
☐ Begun Puberty
☐ Birth Control
☐ Currently Pregnant
☐ Difficulties with Sexual Orientation
☐ Excessive Anxiety
☐ Excessive Flirting
☐ Gender Identity
☐ Previous Pregnancy
☐ Sexually Active
☐ Sexually Reactive Behavior
☐ Sexually Transmitted Disease
☐ Other (explain below)

Description of Sexual History/ Concerns:

_____

SECTION 10 - EDUCATIONAL HISTORY

Name of Current or Most Recent School: _____

Address: _____ Grade: _____

Current Individualized Education Plan (IEP)? ☐ Yes ☐ No Current 504 Plan? ☐ Yes ☐ No

Has your child been suspended from school? ☐ Yes ☐ No If **yes**, what grade(s)? _____

What behaviors led to being suspended?

_____

Schools Attended:	Grade	Problems? Yes/No	(Learning or Behavioral? When?) Comments
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____
_____	_____	☐ / ☐	_____

Has your child ever been employed? ☐ Yes ☐ No

Trials/Career Interests:

_____

SECTION 11: CHILD'S SUBSTANCE USE HISTORY/EXPOSURE

Client has a History of Substance Use: ☐ Yes ☐ No ☐ Unknown

Early Childhood Exposure to Substance Use: ☐ Yes ☐ No ☐ Unknown

Previous Substance Abuse Services: ☐ Yes ☐ No ☐ Unknown

Substance Use: *(if indicated a history of substance use - check all that apply)*

☐ Alcohol
☐ Barbituates
☐ Benzodiazepines (Xanax, Klonopin)
☐ Caffeine
☐ Club Drugs/Hallucinogens
☐ Cocaine/Crack
☐ Heroin
☐ Inhalants
☐ Marijuana
☐ Methamphetamine
☐ Opiates
☐ Over the Counter
☐ Stimulants
☐ Synthetic Marijuana
☐ Tobacco/Nicotine
☐ Other (explain below)

_____

Description of Substance Use and/or Substance Abuse Services, including other involvement with drugs, dealing drugs *(please include age of use)*:

_____

Has your child experienced legal, behavioral or social consequences from the use of alcohol or drugs?

_____

SECTION 12 – FAMILY EXPECTATIONS AND PARTICIPATION REQUIREMENTS

What do you think your child's treatment goals should include?

_____

What are your child's strengths?

_____

What do you think the family treatment goals should include?

_____

Discharge Location and Plan:

_____

When one member of a family comes to Orchard Place Campus, the whole family shares concerns, worries, and the discomfort of separation. Regularly scheduled family therapy sessions and visitation will be planned by you and your family's therapist. Family sessions will be regularly scheduled and you may set up visits with your child through your family therapist.

Weekly family therapy sessions are required. At a minimum, twice per month in-person sessions are required with phone or Skype sessions on the opposite weeks. Having all sessions in-person are preferred, when possible. Family therapy occurs between the hours of 8a—5p Monday-Friday.

Will you be able to participate weekly? ☐ Yes ☐ No

Preferred session day and time: _____

Do you have the capabilities for Skype sessions? ☐ Yes ☐ No

Do you have means of getting to your appointments at the Orchard Place Campus? ☐ Yes ☐ No

Will you be able to visit your child regularly on campus? ☐ Yes ☐ No

When your child has progressed in treatment, will you be able to have your child come home for visits? ☐ Yes ☐ No

In addition to family therapy, we also ask out parents/guardians to attend scheduled Psychiatric Review/Treatment Planning Sessions, or staffings, as part of the treatment team. Staffings provide an opportunity to hear progress reports from the unit, school, therapist and psychiatrist as well as participate in treatment planning and review. These are held around 30 days after admission and every quarter thereafter. Staffings are held during normal business hours to accommodate the psychiatrist schedules and any other professionals involved in your child's treatment.

Would you be able to attend regularly scheduled staffings? ☐ Yes ☐ No

Would you be able to attend informational trainings/parenting classes/support groups? ☐ Yes ☐ No

Do any parents/guardians or therapy participants require accommodations such as language translator, wheelchair accessibility, hearing impaired services, etc. If yes, please list below.

_____

To my knowledge, the above information is complete and accurate. I understand that failure to provide information could result in unsuccessful treatment.

_____ _____

Signature ***Date***