Hello!

If you're receiving this behavioral health intake packet, it is because your child's primary care provider and you have discussed that your child can benefit from additional behavioral health services.

Your child's primary care provider has referred you to the OSF Pediatrics Behavioral Health Team, located at Edwards Clinic, 144 North Court, in Dixon. The OSF Pediatrics Behavioral Health Team works closely with the team at Florissa, located in the lower level of OSF Edwards Clinic. Florissa is a division of Kreider Service and is a separate organization from OSF Saint Katharine Medical Center.

The information completed in this behavioral health intake packet may be used for the following purposes:

- **Diagnostic Evaluation at Florissa** by a child psychologist for problems such as developmental delays, inattention, impulsivity, hyperactivity, academic struggles, social struggles, sadness, anxiety, anger, and defiance. If your child has already received a diagnosis, there may be more specific clarifying questions about the diagnosis or a need to understand any co-occurring problems and how they are connected.
- **Medication Management for behavioral health problems at OSF Saint Katherines Medical Center**. OSF Pediatrics currently has a nurse practitioner who has specialized training and experience working with behavioral health conditions.
- **Counseling/Therapy Services**
- **Parent Consultation Services**

Please fill out the packet to the best of your ability. Any parts of the intake packet that you are uncertain about what to write can be left blank and filled in with staff at a later time.

*For children ages 12 years & older please have them sign the following:

- Florissa Authorization for Release of / Request of Records and Information
- OSF Authorization for Release of Medical Information
    - Child's name to be placed in *Patient Information and Release of Medical Records From* sections.
    - Parents' names to be placed in *Release of Medical Records To* section.

When the packet is complete, please return the packet to your child's primary care provider or you can bring it to Edwards Clinic and give it to staff at the front desk.

We look forward to working with you and your child!

- The Pediatric Behavioral Health Team at OSF Pediatrics

Referring PCP: _____

Referral Date: _____

Patient Name: _____

MRN: _____

(to be completed by Peds staff)

PEDIATRICS BEHAVIORAL HEALTH REFERRAL

This form must be submitted to the OSF Saint Katharine Pediatric Clinic BEFORE an initial behavioral visit

CHILD DEMOGRAPHIC INFORMATION			
Name of Person Completing Form:			Relationship to Child:
Date Form Completed:			
Child's First Name:		Child's Last Name:	
Date of Birth:	Age:		Sex: ☐Female ☐Male
Gender Identity: ☐Female ☐Male ☐Transgender Female ☐Transgender Male ☐Other: _____			
Child's Primary Address:			
City, State, Zip:			County:
Current School:	Grade:		Primary Teacher:
It is our policy to provide equal opportunity to all persons regardless of their race, sex, color, religion, national origin, immigration status, physical or mental disability. Your assistance in voluntarily completing this section will help provide the information we need for statewide data reporting requirements.			
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino	Race: ☐American Indian/Alaska Native ☐Black or African American ☐White or Caucasian		☐Asian ☐Native Hawaiian or Other ☐Pacific Islander ☐Other
Primary Language Spoken in the Home:			Last 4 digits of SSN (if applicable):
Services requested: ☐Testing / Evaluation ☐Therapy ☐Parent Consultation			For what?
What are you hoping is a result of these services?			

CHILD AND FAMILY STRENGTHS
What does your child like to do in his/her free time? What recreational activities does your child participate in?
About how much time does your child spend on "screens"? Please explain.
List at least three adjectives to describe your child:
What are your child's strengths?
List at least three adjectives to describe your family:
What are your family's favorite activities?

CHILD BEHAVIORAL CONCERNS *Please check the box if your child has difficulty with any of the following problems. If yes, please explain.*		
√	**Behavior/Symptom:**	**Please describe:**
	Has difficulty taking care of self or doing daily self-care routines?	
	Has difficulty learning? School problems?	
	Seems sad or depressed?	
	Has thoughts of suicide?	
	Hurts self on purpose?	
	Frequently and abruptly changes moods?	
	Has difficulty managing anger?	
	Has frequent tantrums?	
	Has trouble meeting new people? Is shy or withdrawn?	
	Is overly anxious? Worries a lot?	
	Has fears about specific things or situations?	
	Has trouble leaving parents or being alone?	
	Avoids tasks that require effort?	
	Has problems concentrating?	
	Makes careless mistakes?	
	Is forgetful? Has difficulty remembering things?	
	Has trouble playing quietly?	
	Is overly active? Has trouble sitting still?	
	Refuses to follow adults' requests or rules?	
	Deliberately annoys people?	
	Is often angry or resentful?	
	Threatens or intimidates others?	
	Is physically cruel to other people or animals?	
	Lies often?	
	Sees or hears things others do not?	
	Wants to hurt others or has hurt others in the past?	

Any other concerns you have that have not been asked about that you want to make sure we know?

CAREGIVER INFORMATION

Please include biological parents, adoptive, step, or foster parents, and/or grandparents/other family members who assume frequent care of the child, leaving blank any that do not apply to your family.

Primary Caregiver Contact *(PLEASE NOTE: This individual will be contacted for scheduling)*

First Name:	Last Name:	Resides with Child? ☐Y ☐N
Legal Guardian? ☐Y ☐N	Relationship to Client:	DOB:
Address:	City, State, Zip:	
Phone:	Email:	
Employer:	Occupation:	
Marital Status:	Name of Partner (if married/living with a partner):	

Additional Caregiver Contact

First Name:	Last Name:	Resides with Child? ☐Y ☐N
Legal Guardian? ☐Y ☐N	Relationship to Client:	DOB:
Address:	City, State, Zip:	
Phone:	Email:	
Employer:	Occupation:	
Marital Status:	Name of Partner (if married/living with a partner):	

Additional Caregiver Contact

First Name:	Last Name:	Resides with Child? ☐Y ☐N
Legal Guardian? ☐Y ☐N	Relationship to Client:	DOB:
Address:	City, State, Zip:	
Phone:	Email:	
Employer:	Occupation:	
Marital Status:	Name of Partner (if married/living with a partner):	

Additional Caregiver Contact

First Name:	Last Name:	Resides with Child? ☐Y ☐N
Legal Guardian? ☐Y ☐N	Relationship to Client:	DOB:
Address:	City, State, Zip:	
Phone:	Email:	
Employer:	Occupation:	
Marital Status:	Name of Partner (if married/living with a partner):	

SIBLINGS/OTHERS LIVING IN CHILD'S HOUSEHOLD

Name:	Relationship to child:	Age:	Gender:	Medical, Developmental or Behavioral Concerns:

Who cares for the child when parents or caregivers are at work or gone?

For the remainder of this form, please skip any questions/sections that do not apply to your child.

CHILD DEVELOPMENTAL HISTORY

Birth History

Birth Location (Hospital and City):	Weeks/Gestation:	Birth Weight:	Delivery Method:

Were there any problems with pregnancy, labor, delivery, or after birth? ☐Y ☐N
If yes, please describe:

When in the pregnancy did the child's mother find out she was pregnant? _____
During pregnancy, did she take any medicine? ☐Y ☐N Drink alcohol? ☐Y ☐N
Use other substances/drugs? ☐Y ☐N
If yes, please describe:

Developmental Milestones

Did you/your child's physician have concerns regarding your child's physical development? ☐Y ☐N
If yes, please complete:

Did your child…	*by age…*		
roll from tummy to back	6 months	☐Y	☐N
sit without support by	9 months	☐Y	☐N
pull up to stand by	12 months	☐Y	☐N
walk without holding onto anyone or anything	18 months	☐Y	☐N
eat with a spoon	2 years	☐Y	☐N
take some clothes off independently	2 ½ years	☐Y	☐N
put on some clothes independently	3 years	☐Y	☐N

Did you/your child's physician have concerns regarding your child's speech/language development? ☐Y ☐N
If yes, how did your child communicate? *(Check any that apply)*
☐ Signs ☐ Gestures ☐ Points ☐ Leads to ☐ Pictures ☐ Eye Gaze ☐ Tantrums ☐ Other
If yes, please complete:

Did your child…	*by age…*		
make different sounds (ex: "mamama," "bababa")	9 months	☐Y	☐N
try to say 3 or more words besides "mama" or "dada"	18 months	☐Y	☐N
say at least 2 words together (ex: "more milk")	2 years	☐Y	☐N
use action words in a phrase (ex: "doggie run")	2 ½ years	☐Y	☐N
name things when you point and ask, "What's this?"	2 ½ years	☐Y	☐N
ask simple questions (ex: "Where is mommy?")	3 years	☐Y	☐N
talk with you in conversation (2 back-and-forth exchanges)	3 years	☐Y	☐N

Did your child receive Early Intervention (birth to 3 years) services? ☐Y ☐N
If yes, at what age?
What services? ☐Physical Therapy ☐Occupational Therapy ☐Developmental Therapy ☐Speech Therapy

Sensory Development

Is your child either over- or under-responsive to sound, touch, or pain? ☐Y ☐N
If yes, please describe:

Does your child display any nonfunctional or repetitive behaviors? ☐Y ☐N
If yes, which? *(check all that apply)*

☐ Hand-flapping	☐ Light-flickering	☐ Jumping	☐ Repeatedly Playing with Object
☐ Rocking	☐ "TV talk"	☐ Humming	☐ Chewing/Biting/Sucking
☐ Spinning	☐ Other (specify):		☐ Pacing/Pressured Walking

Please skip any questions/sections that do not apply to your child.

CHILD HEALTH HISTORY

Current Medical Information

Date of last physical exam:	Height at exam:	Weight at exam:

Were there any health concerns at the exam? ☐Y ☐N
If yes, please explain:

Date of child's last **HEARING** evaluation:	Results:
Date of child's last **VISION** evaluation:	Results:

Eating Routines

Does your child have any eating difficulties? ☐Y ☐N
If yes, please describe:

Does your child have a special diet? ☐Y ☐N If yes, please describe:	What is your child's typical daily diet?

Sleeping Routines

What time does your child typically go to bed on weeknights?	Weekend nights?
What time does your child typically wake up on weekdays?	Weekends?

What electronics are in your child's bedroom?

Do you have any concerns about your child's sleep? ☐Y ☐N
If yes, please check your concerns: ☐Falling asleep ☐Staying asleep ☐Too much sleep ☐Not enough sleep

Medical History *(Please check next to any condition your child currently has or previously had)*

√	Conditions or Illnesses:	Explain:	√	Conditions or Illnesses:	Explain:
	Head Trauma/Concussions			Endurance/Strength	
	Seizures			Genetic Syndrome	
	Tics/Tourette's			Heart or Lungs	
	Asthma			Diarrhea or Vomiting	
	Heart Disease			Eating or Swallowing	
	Hearing/Ear Problems			Muscles or Bones	
	Recurrent Ear Infections/Tubes			Skin (e.g., rashes)	
	Esophageal Reflux (GERD)			Thyroid or Other Hormones	
	Anemia			Frequent Infections	
	Surgeries/Hospitalizations			Growth/Weight Problems	
	Allergies to Food/Medicine:			Chronic Pain	
	Constipation/Toileting Concerns			Nose/Throat (e.g., allergies, snoring)	
	Lead Exposure			Vision/Eye Problems	

Current Medical & Mental Health Diagnoses *(Please provide any information not addressed above)*

Has your child been given any medical or mental health diagnoses not addressed above? ☐Y ☐N
If yes, please complete the following:

Diagnosis Received	*Age Given*	*Diagnosing Provider*	*Agency*

Please skip any questions/sections that do not apply to your child.

Medication and Treatment Information

Does your child currently take any medication? ☐Y ☐N

If yes, please complete the following:

Medication Name	*Date Started*	*Dosage*	*Times per Day*	*Purpose*

Has your child had any negative reactions to medication? ☐Y ☐N

If yes, please explain:

Has your child previously received services for a mental health diagnosis? ☐Y ☐N

If yes, please complete the following:

Service/Intervention Type	*Date Range*	*Minutes Per Week*	*Service Provider*	*Successful?*

FAMILY HISTORY

*(please check next to condition(s) and list relative indicating **M**aternal or **P**aternal side)*

√	Condition:	Relation to child:	√	Condition:	Relation to child:
	Autism/PDD/Asperger's			Asthma	
	ADHD			Allergies	
	Learning Disorder			Intellectual Disability	
	Speech Problems			Alcohol/Drug Abuse	
	Seizure Disorder			Oppositional Defiant Disorder	
	Tic Disorder/Tourette's			Depression	
	Bipolar Disorder			Anxiety	
	Schizophrenia			Eating Disorder	
	Heart Condition			Serious Vision/Hearing Problem	
	Thyroid Disease			Diabetes	
	Other (please describe)			Genetic Syndrome	

Please skip any questions/sections that do not apply to your child.

ACADEMIC HISTORY

Does/did your child attend daycare? ☐Y ☐N If yes, how long?

Does/did your child attend preschool? ☐Y ☐N If yes, how long?

Please provide the following information regarding your child's academic history:

School Name	*Grades Attended*	*List Any Services Received (e.g., counseling, Title I, resource room, speech, OT, PT, problem-solving team)*

Does/did your child have an Individualized Education Plan (IEP) or 504 Plan at school? ☐Y ☐N
For what? (i.e., Eligibility Category):

SOCIAL FUNCTIONING

Does your child initiate interactions with peers? ☐Y ☐N

Does your child try to make friendships? ☐Y ☐N

Does your child have peer friendships? ☐Y ☐N
If yes, please describe friendships:

Does your child experience problems with transitions or changes in routine? ☐Y ☐N
If yes, please describe:

Does your child have difficulty engaging in conversation? ☐Y ☐N
If yes, please describe:

Does your child use eye contact appropriately? ☐Y ☐N
If no, please describe:

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AUTHORIZATION FOR RELEASE OF / REQUEST OF RECORDS AND INFORMATION

Child's Name: _____ Date of Birth: _____

I authorize Florissa, 144 North Court, Dixon, IL 61021 to release and/or obtain specific information regarding the above named child from or to the agency/individual below:

Release to	Obtain from		Specific information to be disclosed:
[ ]	[ ]	OSF Saint Katharine Pediatrics Dixon, IL 61021 Ph: 815-285-5437 Fax: 815-285-8928	All information on child for consultation and evaluation purposes as needed

- The purpose of this disclosure information is for the following: assessment and treatment planning.
- Unless otherwise indicated, this consent is valid until: _____ (not to exceed one year from date of signature).
- **I understand that I have the right to review this information being released and may revoke this consent at any time; however, the revocation must be in writing. I understand that no revocation of the consent shall be effective to prevent disclosure of information until it is received by the person otherwise authorized to disclose the records and communication.**
- This information may be released by mail, phone, fax, electronic transmission or you may restrict its release to only the following: _____.
- Refusal to consent to release of information specified above will result in the following consequence(s): unable to obtain records for evaluation and continuity of care.
- It is my full understanding that the records and communications to be disclosed may contain evaluation/treatment for mental health, developmental disabilities, educational, psychiatric, medical or genetic information and that my signature indicates my informed consent.
- I understand that this information may not be forwarded to another individual, agency or organization without my written consent. I understand that I have the right to inspect, copy, and challenge the information contained in the records received.
- I certify that I am the parent or legal guardian of the above named child and have the authority to sign this release.

_____ _____
Signature of Individual (age 12 or older) Date

_____ _____
Parent/Legal Guardian of Individual (Under 18 or legally disabled) Relationship Date

_____ _____
Witness (2nd parent/guardian may sign here) Date

NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), you may not redisclose any of the information unless the person who consented to disclosure specifically consents to such redisclosure. Under the Federal Act of July 01, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information for such records may be further disclosed without specific authorization for such redisclosure.