☙ Made It Clinic Intake Checklist (Adolescent - Parent) V4.18

Thank you for choosing to access services through the Made It Clinic. Regardless of the duration of time you are with us, we want to do an ethical, thorough and professional job. In psychology, this looks like a million questions and forms.

Set aside about 30 minutes to complete all the paperwork. This will help you and your psychologist clarify what is going on.

Here is a checklist to help you keep track of all you need to bring to your first session. Not all these documents will apply to you.

Initial Appointment

- ☐ Consent form (Client, Parent to co-sign)
- ☐ Intake questionnaire (Client)
- ☐ Intake questionnaire (Parent)
- ☐ Rating scales and measures (separate for Parent and Client)
- ☐ Payment method

Other documents that you might have:

- ☐ Referral letter from your specialist or doctor
- ☐ Medicare and health care cards
- ☐ Relevant health records including previous assessments and school/work reports
- ☐ Contact information for stakeholders, support workers, and organizations that the Made it Clinic may need to work with

Ongoing Appointments

- ☐ Any home activities assigned in the previous week
- ☐ Any scales or measures to be completed before the session
- ☐ Payment method

Do not sign anything that you do not understand. Bring the documents to your first session and clarify this with your psychologist.

If you don't complete or bring anything, it's still ok to just show up.

😊

Please complete this prior to attending with your child. If you don't know the information, or if you do not understand the question, leave the item blank. ☒ N/A = not applicable.

Child's Name: Child's Surname:

Child's Date of Birth: Today's Date:

Your name: Your caregiver role:

Contact number:

Address:

Email:

Referrer (Name, Profession, Contact Details):

☐ N/A

School: Grade:

Teacher's Name: Teacher's Contact:

Emergency Contact - Name:

Emergency Contact - Contact Information:

Emergency Contact - Relationship to child:

Will contacting you using the above information impact your child's safety? ☐ YES ☐ NO

If YES, how would you like to be contacted:

Would you like to receive email or SMS reminders for future appointments?

☐ Email ☐ SMS ☐ None

How would you rate your contact with the Made it Clinic so far? *Please circle one*

Very poor Poor Average Good Excellent

Would you be interested in being contacted for feedback after you have completed services with the Made it Clinic? ☐ YES ☐ NO

Presenting Issue: *Briefly describe your main concern or reason for making an appointment*

When did you (or others) first notice this concern? ☐ N/A

How much does the issue impact <u>your child's</u> functioning now? *Circle one number* ☐ N/A

Not much *Very Much*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much does the issue distress <u>your child</u> now? *Circle one number* ☐ N/A

Not much *Very Much*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much does the issue impact <u>your</u> functioning now? *Circle one number* ☐ N/A

Not much *Very Much*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much does the issue distress <u>you</u> now? *Circle one number* ☐ N/A

Not much *Very Much*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How motivated are you to work together on this issue? *Circle one number* ☐ N/A

Not Much *Very Much*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What makes the issue worse? What situations or actions increase disfunction and distress?

What makes the issue better? What situations or actions improve functioning?

How do you motivate your child?

- ☐ Rewards (e.g. stickers, toys, money)
- ☐ Taking items away
- ☐ Taking privileges away
- ☐ Bribing
- ☐ Guilt and shame
- ☐ Encouragement
- ☐ Less chores
- ☐ Exclusion from fun activities
- ☐ Point out natural causes and consequences
- ☐ Tell him/her you are disappointed
- ☐ Talk through thoughts and feelings
- ☐ Other (specify):
- ☐ Praise
- ☐ Grounding
- ☐ Negotiating
- ☐ Shouting/loud noises/growling
- ☐ Posts on social media
- ☐ Hitting
- ☐ Time out (to calm down, not to exclude)
- ☐ Inclusion in decision making
- ☐ Reflection on actions
- ☐ To-do list
- ☐ Hugs/affection

Additional Concerns: *Indicate any additional concerns and provide detail* ☐ N/A

- ☐ Excessive crying
- ☐ Social media/internet
- ☐ Parent relationships
- ☐ Lying/Stealing
- ☐ Toileting
- ☐ Pain
- ☐ Stress
- ☐ Stuttering
- ☐ Alcohol/Substance Use
- ☐ Separation anxiety
- ☐ Procrastination
- ☐ Domestic violence
- ☐ Unusual perceptual experiences
- ☐ Shy/nervous
- ☐ Mood swings
- ☐ Sibling relationships
- ☐ Harm to humans/animals
- ☐ Eating/Feeding
- ☐ Adjustment difficulties
- ☐ School refusal
- ☐ Poor schoolwork
- ☐ Low self confidence
- ☐ Communication difficulties
- ☐ Self-harm
- ☐ Chronic illness
- ☐ Repetitive behaviour/rituals
- ☐ Sleeping
- ☐ Concentration difficulties
- ☐ Friendships
- ☐ Destruction of property
- ☐ Grief and loss
- ☐ Conduct (home only)
- ☐ Hyper-focus/obsessive
- ☐ Parent separation
- ☐ Gaming/computers
- ☐ Anger
- ☐ Suicidal thoughts/actions
- ☐ Conduct (classroom only)
- ☐ Concerning sexual behaviour

Additional Details and Other Concerns:

Have you sought support for these issues before? *If so, briefly list the services and approaches used to address the issues in the past.* ☐ N/A

Issue:	*Service/approach:*
Dates of support:	*Number of sessions:*
Outcome:	

Issue:	*Service/approach:*
Dates of support:	*Number of sessions:*
Outcome:	

Other Stakeholders and Caregivers: *Who else is involved in the care of your child? What organizations/adults/adolescents does your child come into frequent contact with?* ☐ N/A

Name:	Role:	Influence: 😊 😐 ☹
Name:	Role:	Influence: 😊 😐 ☹
Name:	Role:	Influence: 😊 😐 ☹
Name:	Role:	Influence: 😊 😐 ☹

DEVELOPMENTAL HISTORY

Please note any difficulties/illnesses/disruptions/major events in your child's developmental history:

Conception/fertilization	_____	☐ N/A
Early pregnancy	_____	☐ N/A
Late pregnancy	_____	☐ N/A
Delivery/Birth	_____	☐ N/A
Early infancy	_____	☐ N/A
From 2 – 5 years	_____	☐ N/A
From 6 – 12 years	_____	☐ N/A
From 13 – 16 years	_____	☐ N/A

As an infant, did the child like to be held? ☐ YES ☐ NO

As an infant, what was the child's temperament?

☐ Grumpy/sad	☐ Friendly	☐ Unresponsive/flat	☐ Hard to settle
☐ Easily upset/startled	☐ Fussy/irregular	☐ Calm	☐ Cautious/slow to warm to strangers

Did the <u>child</u> meet developmental milestones on time? *If not, which were late/significantly early?*

☐ Yes

Did the <u>mother</u> smoke cigarettes during pregnancy? *If so, how many per week?*

☐ No

Did the <u>mother</u> consume illegal substances during the pregnancy? *If so, what type and how much per week?*

☐ No

Did the mother use prescription medicine that was not prescribed to her? *If so, what type and how much per week?*

☐ No

Did the mother experience significant illness or conditions, including mental illness during or shortly after pregnancy? *If so, please describe:*

☐ No

Did the mother have any pregnancies that did not come to term previously? *If so, what year(s)?*

☐ No

Is the father involved in parenting? *If so, what tasks?*

☐ N/A

Did the father experience significant illness or conditions, including mental illness during or shortly after pregnancy? *If so, please describe:*

☐ No

Was the father using illicit substances or drinking alcohol excessively during conception or pregnancy? *If so, what is the type and quantity?*

☐ No

Please list any of your child's health conditions, surgeries, or major illnesses including mental health:

☐ N/A

Issue:	Onset:	Treatment:	☐ C
Issue:	Onset:	Treatment:	☐ C
Issue:	Onset:	Treatment:	☐ C
Issue:	Onset:	Treatment:	☐ C
Issue:	Onset:	Treatment:	☐ C

Indicate " ☒ C " for CURRENT TREATMENT

Please list any events where the child was separated and distressed for a period of 2 weeks or longer from their primary caregiver *(e.g. parental separation, illnesses in family, unexpected circumstances):*

_____

☐ N/A

_____

What is the father's usual occupation? _____ ☐ C

What is the mother's usual occupation? _____ ☐ C

What are other significant caregivers' usual occupation(s) (if applicable)? _____ ☐ C

Indicate " ☒ C " for CURRENTLY EMPLOYED

Indicate any illnesses or conditions and indicate whether they are from the mother (M) or father's (F) side of the family:

☐ High blood pressure	☐ M ☐ F	☐ Depression	☐ M ☐ F
☐ Diabetes	☐ M ☐ F	☐ Anxiety	☐ M ☐ F
☐ Obesity	☐ M ☐ F	☐ Psychosis	☐ M ☐ F
☐ Stroke	☐ M ☐ F	☐ Alcoholism	☐ M ☐ F
☐ Cancer	☐ M ☐ F	☐ Addiction	☐ M ☐ F
☐ Immunodeficiency	☐ M ☐ F	☐ Sensory differences	☐ M ☐ F
☐ Autism	☐ M ☐ F	☐ Attention/Hyperactivity	☐ M ☐ F
☐ Asthma	☐ M ☐ F	☐ Personality disorder	☐ M ☐ F
☐ Chromosome abnormality	☐ M ☐ F	☐ Intellectual impairment	☐ M ☐ F
☐ Blood disease (specify):	☐ M ☐ F	☐ Intolerances (specify):	☐ M ☐ F

_____ _____

☐ Other (specify): ☐ M ☐ F

_____

☐ Other (specify): ☐ M ☐ F

_____

CHILD SOCIAL/OCCUPATIONAL HISTORY

Who does the child currently live with? *Who resides at the same address as the child?*

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Please list past and present schools/institutions your child attends:

School:	Year:
School:	Year:
School:	Year:

Has your child repeated any years of education? If so, which: _____

What is your child's favourite school subject and why?

_____

Who is your child's favourite teacher and why?

_____

What are your child's hobbies/interests?

_____

What are your child's strengths?

_____

Does your child have a stable group of friends. If so, how many?

Influence: 😊 😐 ☹

_____

How many hours a week does your child engage in:

paid employment? ☐ N/A

education/training? ☐ N/A

volunteer and home activities? ☐ N/A

leisure activities? ☐ N/A

Any additional concerns or comments?

☐ No

OTHER INFORMATION

What are your main goals in accessing services through the Made it Clinic? *(What do you want to accomplish at the end of the service?)*

Is there any other information you would like the Made it Clinic to know for the purpose of service provision? *If so, note them here:*

Are there any current or imminent legal issues related to your child? *If so, please specify:*

☐ N/A

Do you think the Made it Clinic would require additional information from your child's school to administer services? ☐ YES ☐ NO

Will the Made it Clinic be required to work with/provide recommendations to your child's school to achieve desired outcomes? ☐ YES ☐ NO

Thank you for your time in completing this form. Please bring this form and other completed paperwork with you to your child's first session at the Made it Clinic. If all paperwork is completed, the first session will likely involve 10 minutes of clarification and information gathering, 15 minutes observation of your child, 10 minutes of treatment planning and 15 minutes for questions, psychoeducation, and skills training.

Date: _____ **RCADS-P**

Name/ID: _____ **Relationship to Child:** _____

Please put a circle around the word that shows how often each of these things happens for your child.

1. My child worries about things	Never	Sometimes	Often	Always
2. My child feels sad or empty	Never	Sometimes	Often	Always
3. When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
4. My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
5. My child feels afraid of being alone at home	Never	Sometimes	Often	Always
6. Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
7. My child feels scared when taking a test	Never	Sometimes	Often	Always
8. My child worries when he/she thinks someone is angry with him/her.	Never	Sometimes	Often	Always
9. My child worries about being away from me	Never	Sometimes	Often	Always
10. My child is bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always
11. My child has trouble sleeping	Never	Sometimes	Often	Always
12. My child worries about doing badly at school work	Never	Sometimes	Often	Always
13. My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
14. My child suddenly feels as if he/she can't breathe when there is no reason for this.	Never	Sometimes	Often	Always
15. My child has problems with his/her appetite	Never	Sometimes	Often	Always
16. My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
18. My child has trouble going to school in the mornings because of feeling nervous or afraid.	Never	Sometimes	Often	Always
19. My child has no energy for things	Never	Sometimes	Often	Always
20. My child worries about looking foolish	Never	Sometimes	Often	Always
21. My child is tired a lot	Never	Sometimes	Often	Always
22. My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
23. My child can't seem to get bad or silly thoughts out of his/her head.	Never	Sometimes	Often	Always

24. When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
25. My child cannot think clearly	Never	Sometimes	Often	Always
26. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
28. When My child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
29. My child feels worthless	Never	Sometimes	Often	Always
30. My child worries about making mistakes	Never	Sometimes	Often	Always
31. My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32. My child worries what other people think of him/her	Never	Sometimes	Often	Always
33. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
35. My child worries about what is going to happen	Never	Sometimes	Often	Always
36. My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. My child thinks about death	Never	Sometimes	Often	Always
38. My child feels afraid if he/she have to talk in front of the class	Never	Sometimes	Often	Always
39. My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40. My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
41. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
43. My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
44. My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45. My child worries when in bed at night	Never	Sometimes	Often	Always
46. My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always
47. My child feels restless	Never	Sometimes	Often	Always