RISE CANYON RANCH

Intake (Child)

Please provide the following information for Rise Canyon Ranch records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as a therapeutic session.

INDIVIDUAL COMPLETING THIS FORM _____

RELATIONSHIP TO CHILD _____

PHONE NUMBER _____

CHILD'S NAME _____

TODAY'S DATE MM/DD/YY ___/___/___

BIRTH DATE / AGE _____

SEX _____

GENDER EXPRESSION _____

RACE / ETHNICITY _____

RELIGION / SPIRITUAL PREFERENCE _____

HOME ADDRESS _____

SCHOOL _____

GRADE _____

TEACHER _____

PARENT OR GUARDIAN _____

PARENT OR GUARDIAN TO WHOM WE CAN RELEASE INFORMATION _____

WHAT IS YOUR MAJOR CONCERN THAT LED YOU TO SEEK HELP FOR THIS CHILD?

WHAT OTHER CONCERNS DO YOU HAVE ABOUT THIS CHILD?

HAS THE CHILD PREVIOUSLY BEEN ASSESSED OR RECEIVED COUNSELING (INCLUDE SCHOOL COUNSELING)? YES / NO

IF YES, PLEASE WHEN, WITH WHOM, ANY TESTING DONE. IF POSSIBLE PLEASE BRING ANY RECORDS OR RESULTS WITH YOU TO YOUR APPOINTMENT.

DOES YOUR CHILD HAVE A PSYCHIATRIST?

YES / NO

IF YES, NAME? _____

ANY HISTORY OF MEDICAL OR PSYCHIATRIC HOSPITALIZATIONS?

YES / NO

IF SO, HOW MANY AND WHERE? _____

Intake (Child)

ANY MEDICINES FOR PSYCHIATRIC PURPOSES? YES / NO

IF YES, PLEASE LIST: _____

MEDICAL HISTORY

PRIMARY CARE PROVIDER _____

DATE OF LAST VISIT _____

ADDRESS _____

WOULD YOU LIKE US TO INFORM YOUR MEDICAL PROVIDER OF THE THERAPY YOUR CHILD RECEIVES HERE? YES / NO

What medical or physical problems has your child had? Please check all that apply, indicating the age and providing further information if necessary:

☐ Visual problems ☐ High fevers ☐ Ear infections ☐ Drug overdose / poisoning ☐ Frequent colds

☐ Headaches / migraines ☐ Strep infections ☐ Serious accidents ☐ Sinus / allergy problems ☐ Seizures

☐ Diabetes ☐ Heart problems ☐ Breathing / respiratory problems ☐ Hearing/speech disorders

☐ Gastrointestinal ☐ Head injury / concussion / whiplash ☐ Skin problems ☐ Cancer

☐ Dental (including grinding, TMJ, etc.) ☐ Other

SURGERIES (TYPE AND DATE)

IS YOUR CHILD CURRENTLY BEING TREATED FOR MEDICAL ISSUES? YES / NO **IF YES, PLEASE DESCRIBE:**

RISE CANYON RANCH

Intake (Child)

MEDICATIONS: **IF YES, PLEASE LIST:**

YES / NO _____

ENVIRONMENTAL ALLERGIES: **IF YES, PLEASE LIST:**

YES / NO _____

FOOD: **IF YES, PLEASE LIST:**

YES / NO _____

PLEASE LIST ALL MEDICATIONS INCLUDING PRESCRIPTION, OVER THE COUNTER, VITAMINS, SUPPLEMENTS, ETC. PLEASE INCLUDE DOSE, HOW LONG YOUR CHILD HAS BEEN TAKING, WHO PRESCRIBES IT.

_____

_____

_____

_____

HAS YOUR CHILD TAKEN ANY MEDICATION FOR ATTENTION, BEHAVIOR, OR MOOD PROBLEMS IN THE PAST? YES / NO

IF YES, PLEASE BELOW INDICATE INCLUDING DOSE, WHAT TAKEN FOR, WHO PRESCRIBED IT AND YOUR CHILD'S RESPONSE.

_____

_____

PLEASE LIST ALL OTHER CURRENT OR PREVIOUS TREATMENTS OR THERAPIES YOUR CHILD HAS UNDERGONE INCLUDING DATES AND EFFECTIVENESS OR RESULTS.

_____

_____

ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? YES / NO

DEVELOPMENAL HISTORY

WERE THERE ANY PROBLEMS OR UNUSUAL CIRCUMSTANCES WITH PREGNANCY OR DELIVERY? YES / NO

IF YES, PLEASE EXPLAIN:

_____

WAS THE BIRTH OF THIS CHILD VAGINAL OR C-SECTION?

_____

WAS THE CHILD ADOPTED? **IF YES, AT WHAT AGE**

YES / NO _____

Intake (Child)

WERE THERE ANY DEVELOPMENTAL DELAYS OR PROBLEMS IN LEARNING TO CRAWL, WALK, USE FINE MOTOR SKILLS OR TALK?

YES / NO / DON'T KNOW

PLEASE EXPLAIN

SLEEP HISTORY

PLEASE DESCRIBE YOUR CHILD'S SLEEP HABITS INCLUDING HOW LONG IT TAKES TO FALL ASLEEP, HOW MANY TIMES HE / SHE WAKES DURING THE NIGHT, AND IF HE / SHE GOES TO SLEEP AND WAKES ON A REGULAR SCHEDULE.

WHAT TIME DOES YOUR CHILD GO TO SLEEP AND WHAT TIME DOES YOUR CHILD USUALLY WAKE UP?

Please check any of the following sleep problems your child has now or has experienced in the past and explain below:

- ☐ Difficulty falling asleep
- ☐ Difficulty waking
- ☐ Not rested after sleep
- ☐ Physically restless sleep
- ☐ Frequent waking during the night
- ☐ Nightmares / bad dreams
- ☐ Sleeping too much
- ☐ Teeth Grinding
- ☐ Restless legs
- ☐ Sleep apnea (stops breathing)
- ☐ Snoring

DAILY ACTIVITY

PLEASE DESCRIBE YOUR CHILD'S SCHEDULE ON A TYPICAL DAY:

WHAT TYPES OF EXERCISE DOES HE/SHE ENJOY, AND FOR HOW MANY HOURS PER WEEK?

HOW MANY HOURS PER DAY DOES YOUR CHILD WATCH T.V.?

Intake (Child)

HOW MANY HOURS PER DAY DOES HE/SHE USE A COMPUTER OR PLAY VIDEO GAMES?

IF YOUR CHILD HAS A CELL PHONE, HOW MANY TEXTS DOES YOUR CHILD AVERAGE A MONTH?

WHAT ARE HIS / HER FAVORITE ACTIVITIES OR HOBBIES?

HOW WELL DOES YOUR CHILD HANDLE PERSONAL HYGIENE? (BRUSHING TEETH AND BATHING DAILY)

NUTRITION

Please describe your child's diet on a typical day:

BREAKFAST

LUNCH

DINNER

SNACKS

APPETITE? GOOD / FAIR / POOR / SPORADIC / AFFECTED BY MEDICATIONS

DOES YOUR CHILD HAVE ANY PROBLEMS WITH FOOD CRAVINGS, DIETING, AND WEIGHT MAINTENANCE? YES / NO

PLEASE EXPLAIN

FAVORITE FOODS

HOW MANY SODAS, SPORTS DRINKS OR SUGARED JUICES DOES YOUR CHILD DRINK IN A DAY?

HOW MANY CAFFEINATED BEVERAGES DOES HE / SHE DRINK IN A DAY?

WHAT IS YOUR CHILD'S REACTION TO CAFFEINE OR OTHER STIMULANTS SUCH AS COLD MEDICINE?

FOOD AVERSIONS OR SENSITIVITIES?

RISE CANYON RANCH

Intake (Child)

DOES YOUR CHILD USE ANY SUGAR SUBSTITUTES OR EAT/DRINK DIET OR SUGAR SUBSTITUTED FOOD OR BEVERAGES?

YES / NO

IF YES, WHAT SUBSTITUTES?

HAVE YOU TRIED ANY DIETARY RESTRICTIONS? YES / NO **IF YES, WHAT, WHEN, AND WHY:**

DOES YOUR CHILD CURRENTLY USE ANY ALCOHOL OR RECREATIONAL DRUGS? YES / NO

IF YES, PLEASE DESCRIBE TYPES, FREQUENCY AND HOW IT AFFECTS YOUR CHILD.

WHAT IS HIS/HER REACTION TO ALCOHOL OR OTHER DEPRESSANTS?

DOES YOUR CHILD USE ANY MEDICATIONS (OVER THE COUNTER/PRESCRIPTION OR RECREATIONAL) FOR PURPOSES OTHER THAN DESCRIBED?

YES / NO

IF SO, PLEASE LIST:

WHEN WAS THE LAST TIME YOU SUSPECT OR KNOW YOUR CHILD USED?

DOES YOUR CHILD USE ANY TOBACCO PRODUCTS? YES / NO **IF YES, WHAT AND HOW MUCH PER DAY?**

FAMILY / SOCIAL DEVELOPMENT

WHAT IS THE CHILD'S CURRENT LIVING SITUATION?

Intake (Child)

Has your child experienced disruptions or upsets involving the family including births, deaths, illnesses, marital changes, changes in family structure or living arrangements, parental or household member conflicts, financial problems, drug or alcohol abuse, changes in school situations, or any other significant events or issues? Please explain:

ARE YOU AWARE OF ANY ABUSE (PHYSICAL, SEXUAL, EMOTIONAL, VERBAL) OR TRAUMA IN THIS CHILD'S BACKGROUND? YES / NO

IF YES, PLEASE DESCRIBE:

PLEASE INDICATE IF YOUR CHILD HAS DIFFICULTY WITH ANY FOLLOWING AREAS AND DESCRIBE BELOW:

- ☐ Inattention
- ☐ Impulsivity
- ☐ Irritability
- ☐ Anxiety
- ☐ Distractibility
- ☐ Fears
- ☐ Obsessive thoughts / worries
- ☐ Panic attacks
- ☐ Daydreaming
- ☐ Depression
- ☐ Agitation
- ☐ Phobias
- ☐ Poor concentration
- ☐ Poor insight
- ☐ Stimulus seeking
- ☐ Angry tantrums
- ☐ Compulsive behavior
- ☐ Muscle / verbal tics
- ☐ Lack of remorse
- ☐ Bed wetting
- ☐ Bowel difficulties
- ☐ Inability to read social cues
- ☐ Poor self-esteem
- ☐ Poor peer relations
- ☐ Poor sibling relations

WHAT CONDITIONS OR TRIGGERS SEEM TO WORSEN THIS CHILD'S BEHAVIOR?

WHAT HELPS TO CALM OR REGULATE BEHAVIOR FOR THIS CHILD?

HAS THE CHILD EVER BECOME VIOLENT OR DESTRUCTIVE? HAS HE/SHE EVER HURT AN ANIMAL OR PERSON INTENTIONALLY OR THREATENED TO HARM OR KILL SOMEONE OR SOMETHING?

Intake (Child)

WHAT PROBLEMS, IF ANY, HAS YOUR CHILD HAD WITH AUTHORITY, GETTING INTO TROUBLE, UNLAWFUL BEHAVIOR THAT COULD (OR HAS) CAUSED LEGAL PROBLEMS?

ARE YOU AWARE OF ANY SUICIDAL THOUGHTS OR ACTIONS OF THIS CHILD? IF YES, PLEASE DESCRIBE.

FAMILY MEDICAL HISTORY

PLEASE CHECK ANY APPLICABLE CONDITIONS OR DISEASES AND INDICATE WHICH FAMILY MEMBER IS AFFECTED:

- ☐ ADD / ADHD
- ☐ Allergies
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism / Aspergers
- ☐ Bipolar disorder
- ☐ Bleeding problems
- ☐ Cancer
- ☐ Color disease
- ☐ Dementia
- ☐ Depression
- ☐ Developmental disorders
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Epilepsy / Seizures
- ☐ Gastrointestinal
- ☐ Headaches / migraines
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Learning disabilities
- ☐ Mental disorders
- ☐ Skin disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tics / tremor
- ☐ Ulcers

SCHOOL HISTORY

PLEASE INDICATE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING PROBLEMS AND AT WHAT AGE?

	PRESCHOOL	ELEMENTARY	MIDDLE	HIGH SCHOOL
READING DIFFICULTIES				
Dyslexia (Difficulty learning to read, blend sounds, read smoothly)	☐	☐	☐	☐
Poor tracking (Lose place in line, missing words)	☐	☐	☐	☐
Poor comprehension	☐	☐	☐	☐

RISE CANYON RANCH

Intake (Child)

	PRESCHOOL	ELEMENTARY	MIDDLE	HIGH SCHOOL
MATH DIFFICULTIES				
Poor arithmetic calculations	☐	☐	☐	☐
Poor sequencing, ordering	☐	☐	☐	☐
Poor grasp concept	☐	☐	☐	☐
WRITING DIFFICULTIES				
Poor handwriting	☐	☐	☐	☐
Poor organization	☐	☐	☐	☐
Poor mechanics	☐	☐	☐	☐
BEHAVIORAL PROBLEMS				
Interference with learning	☐	☐	☐	☐
Peer or social problems	☐	☐	☐	☐
Problems in group activities	☐	☐	☐	☐
Disliked or avoided at school	☐	☐	☐	☐
Bullied (including cyber bullying)	☐	☐	☐	☐
Bullying others	☐	☐	☐	☐
Poor visio-spatial skills (drawing, copying)	☐	☐	☐	☐
Poor spelling	☐	☐	☐	☐
Poor sense of direction	☐	☐	☐	☐
Poor balance or coordination	☐	☐	☐	☐

Intake (Child)

PLEASE LIST ANY ISSUES WITH GRADES / SCORES IN SCHOOL

PLEASE DESCRIBE ANY DISCIPLINARY PROBLEMS IN SCHOOL. PLEASE INCLUDE DETENTIONS / SUSPENSIONS, AGE AND GRADE THAT PROBLEMS OCCURRED

PLEASE USE THIS SPACE TO PROVIDE ANY OTHER INFORMATION YOU FEEL WOULD HELP US BETTER UNDERSTAND YOUR CHILD

WHAT ARE YOU AND YOUR CHILD SPECIFICALLY HOPING TO ACHIEVE OR ADDRESS WITH US?

THANK YOU for all your time and effort in completing this lengthy form. We really do appreciate receiving the information we need to understand how each individual child is challenged and gifted. Please bring any records, test results, school results, or pertinent information to your appointment. We look forward to working with you and your child!