RESTORATION THERAPY CENTER OF SD

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Please read, fill in, and where appropriate, sign and bring all completed forms to your first appointment.

Date: _____ **Referred by:** _____

Personal Information — Minor & Parent/Guardian

MINOR

Name: _____

Date of Birth: _____ **Gender:** _____

Home Address: _____
(house number, street, apt. number; city, state, zip code)

Phone: _____ **Email:** _____

Ethnic Identity
(in compliance with CDE)

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino

Racial Identity

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other *(please identify)*: _____

Adopted: ☐ yes / ☐ no

Emergency Contact

Name: _____ Phone Number: _____ Relationship: _____

PARENT/GUARDIAN #1

Name: _____

Date of Birth: _____ **Gender:** _____

Home Address: _____
(house number, street, apt. number; city, state, zip code)

Phone: _____ **Email:** _____

Ethnic Identity
(in compliance with CDE)

□ Hispanic / Latino
□ Not Hispanic / Latino

Racial Identity

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or other Pacific Islander
□ White
□ Other *(please identify)*: _____

Marital Status

□ Single □ Married □ Domestic partnership □ Separated □ Divorced □ Widowed

Children	*Child #1*	*Child #2*	*Child #3*	*Child #4*
Name				
Sex				
Age				
Grade				
Relation to minor *(full, half, step, adoptive)*				

Highest level of education completed □ Less than High school diploma □ High school diploma

□ Associate's degree □ Bachelor's degree □ Master's degree □ Doctoral degree □ Other: _____

Occupation: _____

Emergency Contact

Name: _____ Phone Number: _____ Relationship: _____

PARENT/GUARDIAN #2

Name: _____

Date of Birth: _____ **Gender:** _____

Home Address: _____
(house number, street, apt. number; city, state, zip code)

Phone: _____ **Email:** _____

Ethnic Identity
(in compliance with CDE)

□ Hispanic / Latino
□ Not Hispanic / Latino

Racial Identity

□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or other Pacific Islander
□ White
□ Other *(please identify)*: _____

Marital Status

□ Single □ Married □ Domestic partnership □ Separated □ Divorced □ Widowed

Children [not listed above]	*Child #1*	*Child #2*	*Child #3*	*Child #4*
Name				
Sex				
Age				
Grade				
Relation to minor *(full, half, step, adoptive)*				

Highest level of education completed □ Less than High school diploma □ High school diploma

□ Associate's degree □ Bachelor's degree □ Master's degree □ Doctoral degree □ Other: _____

Occupation: _____

Emergency Contact

Name: _____ Phone Number: _____ Relationship: _____

Presenting Problem & Motivation

Describe your goals / reasons for seeking therapy: _____

_____

What effect has this issue or concern had on your family, ability to work, or daily activities? _____

_____

How long have you been dealing with the issue(s)? _____

What have you done to deal with this issue or concern up to this point? _____

_____

Current level of motivation to change/work on the problem:

(not at all) □ *1* □ *2* □ *3* □ *4* □ *5* *(very much)*

Please describe attributes or characteristics that you view as personal strengths: _____

_____

Is there anything else you would like your therapist to understand regarding you and your goals: _____

_____

Have you ever seen a counselor / therapist before? □ yes / □ no

Presenting Problem & Motivation — Parent/Guardian

Describe your goals / reasons for seeking therapy for your child: _____

_____

What effect has this issue or concern had on your child, family, or daily activities? _____

_____

How long has your child been dealing with the issue(s)? _____

What have you as a family done to deal with this issue or concern up to this point? _____

_____

Please describe attributes or characteristics that you view as your child's personal strengths: _____

_____

Is there anything else you would like your therapist to understand regarding your child: _____

_____

Has your child ever seen a counselor / therapist before? □ yes / □ no

Physical, Mental, & Spiritual Assessment — Minor

PART 1: Physical Assessment

Please describe your general physical health: _____

_____

Any concern that might hinder our work *(e.g., hearing problems)*: _____

PART 2: Mental Assessment

Have you recently thought of harming yourself or hurting someone else?

□ yes / □ no *If yes, please explain:* _____

PART 3: Spiritual Assessment

Religious Affiliation: _____

How central is your faith to your day-to-day life? *(not at all)* □ *1* □ *2* □ *3* □ *4* □ *5* *(very)*

Would you like your faith to be incorporated in our work: □ yes / □ no

Physical, Mental, & Spiritual Assessment — Parent/Guardian

PART 1: Physical Assessment

Please describe your child's general physical health: _____

_____

Any concern that might hinder our work *(e.g., hearing problems)*: _____

Please state any current medical diagnosis of your child, including medication *(name, dosage, frequency)*:

_____

_____

Please list any additional relevant medical history: _____

PART 2: Mental Assessment

To the best of your knowledge, has your child recently thought of harming themself or hurting someone else?

□ yes / □ no *If yes, please explain:* _____

Please state any current psychiatric diagnosis your child has received: _____

_____

Has your child ever taken medications for emotional / psychiatric problems? □ yes / □ no
Use extra space if needed.

Name of Medication	Reason for subscription	Dosage	Frequency	How long did you / have they been taking it?

Has your child ever been hospitalized for psychiatric reasons? □ yes / □ no

If yes, please explain: _____

Name & contact info of psychiatrist: _____

PART 3: Spiritual Assessment

Religious Affiliation: _____

How central is faith to your child's day-to-day life? *(not at all)* □ *1* □ *2* □ *3* □ *4* □ *5* *(very)*

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure — Child Age 11-17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes			☐ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes			☐ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes			☐ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes			☐ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes			☐ No		
	25.	Have you EVER tried to kill yourself?	☐ Yes			☐ No		

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure — Child Age 6-17

Child's Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			