

INNER HARBOUR, LTD.

PARENT/LEGAL GUARDIAN INFORMATION

RESIDENT'S FULL NAME _____ DOB ____/____/____ AGE _____

SEX: MALE FEMALE *RELIGION _____ SS# _____ * RACE: _____

LAST SCHOOL ATTENDED _____ GRADE _____

Insurance # _____

WHO HAS LEGAL CUSTODY OF RESIDENT? _____ RELATIONSHIP TO RESIDENT _____

MOTHER'S NAME _____ DOB: _____ SS# _____

STREET ADDRESS _____ e-mail _____

CITY, STATE, ZIP CODE _____ COUNTY _____

HOME PHONE (____) _____ WORK PHONE (____) _____ BEEPER/CELL (____) _____

EMPLOYER _____ JOB TITLE _____

FATHER'S NAME _____ DOB: _____ SS# _____

STREET ADDRESS _____ e-mail _____

CITY, STATE, ZIP CODE _____ COUNTY _____

HOME PHONE (____) _____ WORK PHONE (____) _____ BEEPER/CELL (____) _____

EMPLOYER _____ JOB TITLE _____

STEP MOTHER'S NAME _____ SS# _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____ COUNTY _____

HOME PHONE (____) _____ WORK PHONE (____) _____ BEEPER/CELL (____) _____

EMPLOYER _____ JOB TITLE _____

STEP FATHER'S NAME _____ SS# _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____ COUNTY _____

HOME PHONE (____) _____ WORK PHONE (____) _____ BEEPER/CELL (____) _____

EMPLOYER _____ JOB TITLE _____

CASEWORKER NAME/OTHER PARTY _____

AGENCY NAME _____ COUNTY _____

e-mail _____

WORK PHONE (____) _____ FAX (____) _____ BEEPER/CELL (____) _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____

HOME PHONE (____) _____ WORK PHONE (____) _____

Guardian Name (if other than parent or caseworker) _____ SS# _____

STREET ADDRESS _____ e-mail _____

CITY, STATE, ZIP CODE _____ COUNTY _____

HOME PHONE (____) _____ WORK PHONE (____) _____ BEEPER/CELL (____) _____

EMPLOYER _____ JOB TITLE _____

PLEASE CONTINUE ON BACK

IMMUNIZATIONS REQUIRED. PLEASE PROVIDE CLINIC NAME AND PHONE NUMBER WHERE IMMUNIZATIONS WERE RECEIVED.

PLEASE LIST SOMEONE BESIDE YOURSELF OR SPOUSE WE CAN CALL IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP TO RESIDENT _____

HOME PHONE (____) _____ WORK PHONE (____) _____ BEEPER/CELL (____) _____

REFERRALS AND CLINICIANS

HAS THIS CHILD BEEN HOSPITALIZED IN THE PAST? YES NO IF YES, PLEASE GIVE NAME OF FACILITY(IES).

AND DATES OF TREATMENT _____

HAS THIS CHILD HAD PSYCHOLOGICAL TESTING DONE IN THE PAST? YES NO IF YES, PLEASE GIVE NAME OF FACILITY

AND/OR PSYCHOLOGIST AND DATES OF TESTING _____

WHO REFERRED YOU TO INNER HARBOUR? NAME/ORGANIZATION _____

ADDRESS, CITY, STATE, ZIP CODE _____

PHONE _____ e-mail _____

IF THERE IS A STATE AGENCY CASEWORKER INVOLVED THAT WILL RECEIVE UPDATES, PLEASE COMPLETE THE SECTION BELOW

NAME/ORGANIZATION _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____ PHONE _____

CELL _____

email _____

NAME/ ORGANIZATION _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____ PHONE _____

CELL _____

email _____

BY SIGNING THIS, I AM CERTIFYING THAT I AM THE LEGAL GUARDIAN OF THE ABOVE NAMED PATIENT.

PARENT/LEGAL GUARDIAN SIGNATURE

_____/_____/_____
DATE

PATIENT SIGNATURE

**INNER HARBOUR, LTD. ADMITS YOUTH REGARDLESS OF RACE, SEX, CREED, COLOR, RELIGION OR NATIONAL ORIGIN*

**INNER HARBOUR, LTD.
PRELIMINARY HISTORY**

IDENTIFYING INFORMATION

PATIENT NAME _____ ADMIT DATE _____

LEGAL CUSTODIAN AND RELATIONSHIP _____

LEGAL ARRANGEMENTS REGARDING VISITATION BY NON-CUSTODIAL PARENT(S) _____

CHIEF COMPLAINT & PRESENTING PROBLEMS _____

INTERVENTIONS/EFFORTS TO ADDRESS PRESENTING PROBLEMS PRIOR TO THIS ADMISSION AND REASON(S) FOR FAILURE _____

HOME ENVIRONMENT

FAMILY COMPOSITION (LIVING INSIDE FAMILY HOME)

NAME	RELATIONSHIP TO PATIENT	AGE	EMPLOYMENT/SCHOOL	MARITAL STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PRELIMINARY HISTORY

FAMILY COMPOSITION (LIVING OUTSIDE FAMILY HOME)

NAME	RELATIONSHIP TO PATIENT	AGE	EMPLOYMENT/SCHOOL	MARITAL STATUS
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SOCIAL, CULTURAL AND ETHNIC ENVIRONMENT _____

PRESSURES, PROBLEMS AND STRESSES IN FAMILY (PATIENT AND/OR FAMILY MEMBERS)

- NEGLECT
- ABANDONMENT
- VERBAL ABUSE
- PHYSICAL ABUSE
- SEXUAL ABUSE
- DEATH OF FAMILY MEMBER
- DIVORCE OF PARENTS
- REMARRIAGE OF PARENT(S)
- EXCESSIVE USE OF ALCOHOL/DRUGS
- MEDICAL PROBLEMS
- MARITAL CONFLICTS
- PARENTING CONFLICTS
- PSYCHIATRIC DISORDER
- MENTAL RETARDATION
- RELIGIOUS CONFLICTS
- CULTURAL PRESSURES
- FINANCIAL PROBLEMS
- SUICIDAL THREATS/ATTEMPTS
- OTHER

DESCRIBE HOW PATIENT AND FAMILY ARE AFFECTED BY ABOVE STRESSORS _____

PATIENT/FAMILY SUPPORT SYSTEMS, INTERESTS, HOBBIES _____

FAMILY HISTORY

MOTHER'S CHILDHOOD HISTORY AND SIGNIFICANT EVENTS/INFLUENCES _____

FATHER'S CHILDHOOD HISTORY AND SIGNIFICANT EVENTS/INFLUENCES _____

STEP-PARENT'S CHILDHOOD HISTORY AND SIGNIFICANT EVENTS/INFLUENCES _____

IF PATIENT IS ADOPTED, LIST WHAT IS KNOWN OF THE BIOLOGICAL FAMILY _____

MARITAL HISTORY OF PARENTS (INCLUDING DIVORCES AND REMARRIAGES) _____

MILITARY HISTORY OF PARENTS AND IMPACT ON FAMILY _____

PRELIMINARY HISTORY

SIGNIFICANT HISTORICAL INFORMATION ABOUT EXTENDED FAMILY MEMBERS

OTHER SIGNIFICANT INFORMATION

CHILDHOOD DEVELOPMENT HISTORY

LENGTH OF PREGNANCY _____ BIRTH WEIGHT _____ PLANNED PREGNANCY UNPLANNED PREGNANCY

HOW DID MOTHER AND FATHER FEEL ABOUT THE PREGNANCY _____

NATURE OF DELIVERY NATURAL FORCEPS CAESARIAN BREECH

DESCRIBE CONDITION OF CHILD AT BIRTH AND ANY COMPLICATIONS _____

IF CHILD WAS ADOPTED, PLEASE GIVE AGE _____ REASONS ADOPTIVE PARENTS DECIDED TO ADOPT _____

AGE OF PARENTS AT TIME OF BIRTH OR ADOPTION _____ MOTHER _____ FATHER

AGE CHILD CRAWLED _____ WALKED _____ TALKED _____ TOILET TRAINED _____

DESCRIBE DEVELOPMENTAL DIFFICULTIES OR DELAYS (IF ANY) _____

DESCRIBE BABY PERSONALITY (INCLUDING AREAS OF SENSITIVITY) _____

DESCRIBE HOW BABY RELATED TO PARENTS AND ENVIRONMENT _____

DESCRIBE HOW PARENTS RELATED TO BABY _____

DESCRIBE SLEEPING AND EATING PATTERN _____



SIGNIFICANT EARLY EVENTS

DESCRIBE HISTORY OF IMPORTANT AND/OR TRAUMATIC EVENTS IN PATIENT'S LIFE (MOVES, SEPARATIONS, HISTORY OF VERBAL, PHYSICAL OR SEXUAL ABUSE, ILLNESS, ACCIDENTS OR INJURY, ABANDONMENT, NEGLIGENCE, ETC.)

DESCRIBE HISTORY OF OUT OF HOME PLACEMENT(S), IF ANY

CULTURAL/RELIGIOUS HISTORY

FAMILY'S RELIGIOUS AFFILIATION _____

LEVEL OF CURRENT RELIGIOUS INVOLVMENT, IF ANY _____

TO WHAT EXTENT DOES THE FAMILY'S RELIGIOUS BELIEF/ACTIVITY PLAY A ROLE IN FAMILY LIFE _____

FAMILY AND INTERPERSONAL RELATIONSHIPS

HOW DOES PATIENT RELATE TO PARENTS/GUARDIAN/AUTHORITY FIGURES _____

HOW DOES PATIENT RELATE TO SIBLINGS _____

HOW DOES PATIENT RELATE TO PEERS _____

PRELIMINARY HISTORY

EDUCATIONAL HISTORY

CURRENT SCHOOL _____

PUBLIC PRIVATE CURRENT GRADE _____ GRADES REPEATED _____
DESCRIBE HISTORY OF SPECIAL NEEDS/CLASSES (IF ANY) _____

DESCRIBE HISTORY OF ACADEMIC PERFORMANCE _____

DESCRIBE HISTORY OF CHANGING SCHOOLS FREQUENTLY (IF ANY) _____

DESCRIBE HISTORY OF BEHAVIOR AT SCHOOL _____

DOES PATIENT HAVE A LEARNING DISABILITY YES NO NOT SURE

IF YES, WHEN WAS DIAGNOSIS _____

DOES PATIENT HAVE ATTENTION DEFICIT DISORDER YES NO NOT SURE

IF YES, WHEN WAS DIAGNOSIS _____

PSYCHIATRIC HISTORY/SUBSTANCE ABUSE

PATIENT'S HISTORY _____

PREVIOUS TREATMENT FOR SUBSTANCE ABUSE PSYCH/BEHAVIORAL CHALLENGES

EATING DISORDER NONE

NAME OF TREATMENT PROVIDER AND DATES _____

PAST IN PATIENT OR OUT PATIENT TREATMENT YES NO

IF YES, PLEASE GIVE NAME OF FACILITY AND DATES _____

DOES PATIENT ATTEND ANY SUPPORT GROUPS YES NO IF YES, PLEASE DESCRIBE BELOW

IF APPLICABLE, PLEASE DESCRIBE PATIENT'S INVOLVEMENT WITH USING/SELLING DRUGS/ALCOHOL RECENTLY OR IN THE PAST. PLEASE BE SPECIFIC ABOUT FREQUENCY AND SUBSTANCES USED.

PARENTS/RELATIVES PSYCHIATRIC HISTORY

NAME OF FAMILY MEMBER	SUBSTANCE ABUSE EATING DISORDER PSYCHIATRIC DIAGNOSIS	OUT PT OR IN PT DATES OR NO TREATMENT

ANY ADDITIONAL COMMENTS

DO PARENTS ATTEND ANY SUPPORT GROUPS YES NO IF YES, PLEASE DESCRIBE

LEGAL HISTORY

PATIENT'S HISTORY

CURRENT LEGAL STATUS

PAST HISTORY OF LEGAL PROBLEMS

PARENT'S/RELATIVES HISTORY

CURRENT LEGAL STATUS

PRELIMINARY HISTORY

PAST HISTORY OF LEGAL PROBLEMS _____

PATIENT AND FAMILY'S EXPECTATIONS REGARDING TREATMENT

DESCRIBE PATIENT'S FEELINGS AND ATTITUDE TOWARD TREATMENT AND WHAT HE/SHE HOPES WILL CHANGE _____

DESCRIBE PARENT'S FEELINGS AND ATTITUDE TOWAD TREATMENT AND WHAT HE/SHE HOPES WILL CHANGE _____

DISCHARGE/CONTINUING CARE PLAN

UPON DISCHARGE, MY CHILD WILL LIVE AT

1ST CHOICE _____

2ND CHOICE _____

3RD CHOICE _____

WHO WILL PATIENT SEE FOR OUT PATIENT THERAPY _____

WHERE WILL PATIENT ATTEND SCHOOL _____

SUPPORT GROUPS NEEDED (CHECK ALL THAT APPLY)

NARCOTICS ANONYMOUS

EATING DISORDERS

ALCOHOLICS ANONYMOUS

OTHER _____

VOCATIONAL/JOB PLACEMENT _____

PATIENT WILL HAVE ACHIEVED THE FOLLOWING _____

