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| **This intake form is to be used by CAMHS clinicians as a guide to collecting relevant information from parents/young person at the initial intake appointment(s).** |
| **Child/Young Person’s Details** |
| **Name:**        | **Address:**       |
| **Gender:**        |
| **Date of Birth:**        |
| **Contact No.:**        |
| **Nationality:**        |

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| **Parents Details** |
| **Name:**        | **Address:**       |
| **Gender:**        |
| **Date of Birth:**        |
| **Contact No.:**        |
| **Nationality:**        |

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| **Consultant Psychiatrist** |
| **Name:** Dr.        | **Contact No.:**        |
| **Address:**  |

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| **CAMHS Key Worker** |
| **Name(s):**  | **Job Title(s):**  |
| **Address:**       | **Phone Number:**       |

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| **Referral Information:**  |
| **Referral Agent:**        | **Date of Referral:**        |
| **Reason:**        |

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| **Family Composition:**  |
| **Detail**  | **Age** | **Occupation/School** |
| **Father** |  |  |
| **Mother** |  |  |
| **Children** |  |  |
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| **Intake Details:**  |
| **Team Members Present**  |
|        |
| **Family Members Present**  |
|        |
| **Format of Intake**  |
|        |
| **Presenting Concerns (Parents/Young person’s view of difficulty/concern)**  |
| *What is your understanding of the reason for referral?:*        |
| *What are your concerns? Who noticed first there was a problem? Whose idea was it to get help? How long has this been a concern?:*        |
| *Context of difficulties/concerns e.g. frequency, intensity (1-10) durations etc….. Are these difficulties evident across settings? Are there situations in which the difficulties are not happening?:*        |
| *How are difficulties managed? What works/helps? What methods of discipline are used with your child?:*        |
| *Can you describe a typical day?:*        |
| **Family Composition, Family History and Genogram**  |
| ***Current living arrangements:*** *Are parents married/living together/separated/access arrangements?* *(if relevant):*        |
| *Who is the child/young person close to? Significant others in his/her life:*        |
| *Family support systems (opportunity for breaks etc.):*        |
| *Family history of developmental/communication/mental and physical health difficulties:*        |
| *Current stressors:*        |
| *Parents own experience growing up (if relevant):*        |

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| **Developmental History**  |
| * *Include details re: pregnancy, birth, postnatal period, motor milestones, gross and fine motor skills, feeding, sleeping, self-care, sensory sensitivities, any ritualistic behaviour, speech/ language and communication development, social skills, mixing/friendships:*
* *Other important life events (e.g. separations, traumas and losses):*
 |
| **Include Adolescent History *(if relevant)***  |
| *Drug and alcohol history include history of cigarette, alcohol or illicit substance use. Check frequency of use, history of intoxication, symptoms of addiction and negative sequelae from use. Psychosexual History.*       |

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| **School Information**  |
| *Schools attended, including pre-school/Montessori/play school. Academic progress made and/or any concerns raised. Any behaviour difficulties, suspensions/expulsions and the reasons for the same. SNA/Resource teaching/special class/special school. History of bullying or being bullied.*       |

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| **Social History**  |
| *Separation difficulties, mixing with peers.*       |

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| **Medical History**  |
| *Any illnesses, hospitalisations, operations, allergies or medication(s) prescribed.*       |
| **Presentation/Observation/Mental State**  |
| *Observations from Initial assessment (include appearance, engagement with therapist and parent, affect, mood, suicidality, and presence/absence of psychotic symptoms, behaviour, insight and motivation).*       |
| **Parental Hopes/Expectations**  |
|       |

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| **Protective Factors**  |
| *What are the strengths and supports in the family? What things do different people in the family do well?*       |
| **Child’s Strengths**  |
| *Hobbies and Interests, Sports/Clubs, Friendships:*       |

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| **Professional help/Intervention received to date**  |
| **Name:**  | **Telephone No.:**  | **Profession:**  |
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| **Other Relevant Information**  |
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| **Formulation/Clinical Summary**  |
| *The presenting difficulty, the context, possible preceding, precipitating and maintaining factors and strengths of the young person and the family.*       |

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| **Summary of Team Discussion and Plan/Recommendations** |
| Key worker assigned  | Consent obtained from young person/parents for assessment/ intervention as appropriate |  Limitations of confidentiality discussed with young person/parent |
| Formulation and plan discussed with young person/parents |  Report Written |  Copy given to YP/ Parent |
| Discussed at Team Meeting | Letter to Referral Agent |  Referral to another agency |
| Liaison with other services |  |   |
| *Further Formal Assessment (e.g. SLT, Psychology, OT, Psychiatry or outside agency e.g. audiology etc):*      |
| *Agreed Plan:*       |
| *Intervention/ treatment: (Individual, Group, Parents Plus, Family):*       |
| **Name:**  | **Signature:**  |
| **Discipline** | **Date:**  |