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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** |
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| **Family Members Present** |
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| **Format of Intake** |
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| **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:** | |