



## Desert Shores Pediatrics Behavioral and Mental Health Services

Please take a moment to review the following guidelines and information to decide if our services are a match for your child/teen's current needs.

1. Our mental and behavioral health services center around **diagnosis and medication management only**. In most cases, counseling or therapy is also recommended, but we do not provide those services.
2. Our providers, including our psychiatric specialist, **do NOT provide therapy or counseling**. We can create a referral and assist in finding options for therapy and other supportive services, but we do not offer therapy at this time.
3. We are not a crisis management facility. If you feel your child is in crisis or suicidal, please call 988 or seek immediate attention at a local Emergency Department or Psychiatric Urgent Care such as Mind 24/7.
4. If your child/teen's needs are considered too complex or a higher level of care is thought to be necessary (e.g. intensive services or more frequent monitoring), we will provide information for psychiatric services outside of Desert Shores Pediatrics.
5. Once medications are stable, it is routine for our psychiatric specialist to have your normal Desert Shores Pediatrics provider manage that medication, which will enable us to help additional patients.
6. Our psychiatric specialist is unable to manage substance abuse issues (addiction) or active eating disorders, which often require a higher level of care and specialized treatments with close monitoring.
7. Desert Shores Pediatrics does not offer formal autism testing and cannot diagnose autism. We can screen for autism, but an additional referral will be necessary for formal testing and diagnosis.
8. To use our psychiatric services, you must be a patient of Desert Shores Pediatrics and intend to use our regular sick and well services for your child/teen as well. We do not accept patients for psychiatric care that intend to keep an outside PCP or pediatrician. The mental health burden is high and our in-house psychiatric specialist is a privilege extended only to our current patients and those that intend to continue all pediatric services with us in the future. Continuity of care is essential and establishing a pediatric home is vital.

Thank you for your interest in Desert Shores Pediatrics Mental and Behavioral Health services.



Desert Shores Pediatrics Behavioral Health Intake Forms

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of person filling out form: \_\_\_\_\_ Relation to pt: \_\_\_\_\_

Parental concerns/reason for visit:

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Family Information

Please list family members in home:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If divorced, please list family members living in other parent's home:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Developmental History

Age of mother at child's birth: \_\_\_\_\_

Was pregnancy full-term (>37 weeks): Yes No: \_\_\_\_\_ weeks Birth weight: \_\_\_\_\_

Mother exposed to toxins/drugs/alcohol during pregnancy: No Yes: \_\_\_\_\_

Mother on any medications during pregnancy: No Yes: \_\_\_\_\_

Any complications during pregnancy: No Yes: \_\_\_\_\_

At what age did your child walk: \_\_\_\_\_ At what age did your child say their first words: \_\_\_\_\_

At what age did you child combine 2-3 words to make a phrase: \_\_\_\_\_

At what age was your child toilet trained: \_\_\_\_\_

Was your child enrolled in AZ Early Intervention Program (AZEIP): \_\_\_\_\_

Has your child ever had speech, occupational or feeding therapy: No Yes: \_\_\_\_\_

Has your child ever been diagnosed with a learning disability: No Yes: \_\_\_\_\_

Does your child have a current IEP/504 plan: No Yes: \_\_\_\_\_

Current Grade: \_\_\_\_\_ Current School: \_\_\_\_\_ Grades: A's B's C's D's F's

Child's Health History

Does your child have chronic health problems (asthma, heart conditions, diabetes): No Yes

If yes, specify: \_\_\_\_\_

Does your child have a history of any of the following:

Heart problems (chest pain, fainting, murmur, rhythm issues): No Yes: \_\_\_\_\_

Dizziness or headaches: No Yes: \_\_\_\_\_

Seizure, tics or other neurological problems: No Yes: \_\_\_\_\_

Glaucoma or other eye problems: No Yes: \_\_\_\_\_

Previous or Current Therapies

Previous or current counseling/therapy: No Yes

If yes, specify name and phone number: \_\_\_\_\_

Any behavioral diagnostic evaluation before (PCP, psychiatrist, hospital, social worker): No Yes

If yes, specify who and when: \_\_\_\_\_

Results/Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Previous or Current Therapies Con't

Was medication prescribed:        No    Yes

If yes, specify name and strength of medication(s): \_\_\_\_\_

\_\_\_\_\_

Any psychiatric hospitalization:    No    Yes

If yes, specify date(s) and location(s): \_\_\_\_\_

Reason for psychiatric hospitalization: \_\_\_\_\_

Any self-harming behaviors (cutting, scratching, headbanging, hitting self):    No    Yes

If yes, specify: \_\_\_\_\_

Any aggression towards others:    No    Yes

If yes, specify: \_\_\_\_\_

Intensive outpatient program or day treatment attendance:        No    Yes

If yes, specify date, location, and diagnosis: \_\_\_\_\_

Any history of physical, mental, or sexual abuse:    No    Yes

If yes, specify, if comfortable: \_\_\_\_\_

Recent stressors in the last year:

Family accident, illness or death:    No    Yes: \_\_\_\_\_

Parental divorce/separation:        No    Yes: \_\_\_\_\_

Loss of job/financial concerns:        No    Yes: \_\_\_\_\_

Family move:                                No    Yes: \_\_\_\_\_

School change:                                No    Yes: \_\_\_\_\_

Other:    Specify: \_\_\_\_\_

Family History (please list family members with any of the following)

Heart Conditions (murmur, rhythm issues, pacemaker): \_\_\_\_\_

Heart attack <50yo: \_\_\_\_\_

High Blood Pressure: \_\_\_\_\_

Thyroid Issues: \_\_\_\_\_

Seizures: \_\_\_\_\_

Migraines: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Family History Con't (please list family members with any of the following)

Depression: \_\_\_\_\_

Anxiety: \_\_\_\_\_

Suicide Attempts/Cutting/Self-Harm: \_\_\_\_\_

Bipolar/Manic: \_\_\_\_\_

Schizophrenia: \_\_\_\_\_

ADHD/ADD: \_\_\_\_\_

Learning Disability: \_\_\_\_\_

Aspergers/Autism/PDD/High Functioning Autism: \_\_\_\_\_

Alcohol problems: \_\_\_\_\_

Substance Abuse: \_\_\_\_\_

Other: \_\_\_\_\_

Please note:

1. Medical providers (Psychiatric NP, MD, DO, NP, PA) are not counselors or therapists. Our primary role is medical diagnosis and discussion of treatment options. Counseling or therapy may be recommended as part of the treatment plan (with or without medications), but we do not have a licensed psychologist, therapist, counselor, or social worker on staff currently.
2. We are not able to appear in court or prepare any reports for court proceedings. Our providers do not get involved in any custody disputes and will not testify or prepare any documents related to custody or other legal matters for parents.
3. Acute mental health emergencies can occur and occasionally our providers will run behind. Please understand that we are diligent about trying to stay on time, but there are circumstances and mental health crises that arise that cannot be ignored. In turn, if your child/teen is ever in need of extra time for additional discussion, treatment, or crisis management, please know that their wellbeing will also be prioritized. Thank you for your understanding.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\*\*\* If you are concerned about ADD/ADHD symptoms including inattentiveness, impulsivity, and/or hyperactivity, please also fill out the Vanderbilt Assessment Forms (parent and teacher). These additional forms are available in-office or on our website under patient forms.\*\*\*