Desert Shores PEDIATRICS

Mental Health and Behavioral Health Services (rev 8/2025)

1. The information provided in this packet is to help us determine the most appropriate care for your child. This may be a provider at Desert Shores Pediatrics, or it may include a referral to a mental and behavioral health specialist or facility.

2. Our office will contact you with additional information within 1-2 weeks after returning the completed packet. If you have a more acute concern, please call for guidance.

3. 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.

4. Our providers **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.

5. 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.

6. If your child'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.

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-care services for your child too. We do not accept patients for psychiatric care that intend to keep an outside primary care provider (PCP) or pediatrician. The mental health burden is high and our in-house services are 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

Desert Shores Pediatrics Behavioral Health Intake Forms

Today's Date: _____ Preferred Provider: _____

Patient's Name: _____ DOB: _____

Name of person filling out form: _____ Relation to pt: _____

Parental concerns/reason for visit:

_____

_____

_____

_____

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 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 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.***