

MERIDELL ACHIEVEMENT CENTER
Psychosocial / Pre-Admission Assessment

(Place name label here)

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **GENDER:** M F

ADDRESS: _____

1. PATIENT CURRENTLY LIVES WITH: _____

2. PROBLEM(S) LEADING TO RESIDENTIAL PLACEMENT / REASON FOR ADMISSION:

3. FAMILY OF ORIGIN:
Patient was raised by: Natural Parents Adoptive Parents Grandparents
 Other: _____
Describe relationship with caregivers: _____

Custody of Child (legal guardian): _____
Custody dispute in progress. No Yes, current status: _____
Describe custody arrangements (if applicable): _____

List names and ages of siblings and whether they are living or deceased:

Describe relationship with sibling(s): _____

Discipline used with patient: _____

Significant issues from childhood impacting current illness: _____

PATIENT NAME: _____

(Place name label here)

4. FAMILY HISTORY OF PHYSICAL AND PSYCHIATRIC DISORDERS:

Family history includes significant physical illness or neurological disorders.

No Yes, describe: _____

Family history includes significant psychiatric illness. No Yes, describe: _____

Family history includes substance abuse. No Yes, describe: _____

Family history includes aggressive behavior or legal problems. No Yes, describe: _____

The patient's current illness has affected family relationships. No Yes, describe: _____

5. DEVELOPMENTAL HISTORY:

Prenatal: Normal or Unremarkable No information available Remarkable for:
(e.g., complications during pregnancy/delivery, substance use) _____

Developmental Milestones: Normal Limits Delayed No information available

Walking: Early: _____ 12-months Later: _____
Talking in 3-word Sentences: Early: _____ 24-months Later: _____

Birth to 1-year: Normal or Unremarkable No information available Remarkable for:

2 to 5 years: Normal or Unremarkable No information available Remarkable for:

6 to 12 years: Normal or Unremarkable No information available Remarkable for:

13 to 18 years: Normal or Unremarkable No information available Remarkable for:

History of head injuries: No Yes, age and details including LOC or residual problems:

History of other neurological problems (e.g., migraines, seizures, blackouts): _____

Current level of functioning: _____

PATIENT NAME: _____

(Place name label here)

6. PATIENT HISTORY OF ALCOHOL AND DRUG USE: N/A

	Type	Year 1 st used	Last Time Used	Age Regular Use Began	Current Use Frequency/Quantity	Highest Quantity in 24-hours
Alcohol						
Stimulants						
Hallucinogens						
Inhalants						
Tobacco						
Marijuana						
Other						

Drug of Choice: _____

7. EDUCATION:

Current Grade Level: _____

Is patient currently enrolled in school?

Yes, Name and Location of School: _____

No, explanation: _____

Current Grades: _____ Usual Grades: _____

Learning Disabilities:

No Yes, description of diagnosis and age at diagnosis: _____

School Behavioral Problems:

No Yes, details (e.g., age of onset, specific behaviors, school consequences): _____

Special Education Services:

No Yes, details (e.g., ages of service, services received, qualifying condition): _____

Family History of School Problems (e.g., LD or ADHD, behavioral problems):

No Yes, describe: _____

School Strengths:

No Yes, describe: _____

PATIENT NAME: _____

(Place name label here)

8. HISTORY OF SUICIDAL IDEATIONS/ATTEMPTS:

Patient has verbalized suicidal ideations. No Yes, when: _____

Patient has verbalized plan. No Yes, describe: _____

Patient has made a suicidal gesture/attempt. No Yes:

Date:	Age:	Method:	Outcome:

Patient has access to a gun or other weapon. No Yes, _____

There are guns or other weapons in the home. No Yes, describe how they are secured: _____

There are other weapons in the home associated with hobbies or collections. No Yes, describe how they are secured: _____

There are other potentially dangerous items in the home (i.e. medications). No Yes, describe how they are secured: _____

If weapons and/or other potentially dangerous items in the home are not secured, develop a specific plan to secure the item(s): _____

9. HISTORY OF VIOLENT/AGGRESSIVE BEHAVIOR:

Patient has been physically aggressive with peers or family members. No Yes, describe (e.g., patient age, nature of assault, victim, extent of injury to victim): _____

Patient has been physically aggressive without provocation, gain or purpose. No Yes, describe _____

Patient has been physically aggressive with a weapon. No Yes, describe (e.g., patient age, victim, weapon used, extent of injury to victim): _____

Patient has threatened others with a weapon. No Yes, describe (e.g., patient age, victim, weapon used): _____

Patient has made verbal threats of violence. No Yes, describe (e.g., patient age, victim, type of threat): _____

Patient has been physically aggressive and/or cruel to animals. No Yes, describe: _____

10. LEGAL HISTORY:

Patient has been arrested. No Yes, describe (e.g., patient age, offense, outcome): _____

Patient is currently on probation/parole. No Yes, name and county of Probation Officer: _____

Patient has charges pending. No Yes, describe (e.g., patient age, offense, court date): _____

Current illness has affected legal history. No Yes, describe: _____

PATIENT NAME: _____

(Place name label here)

11. SOCIAL/SEXUAL:

Patient is able to create and maintain friendships.
Patient is able to relate to peers in a respectful manner.
Patient is able to relate to adults in a respectful manner.
Patient is sexually active.
Patient practices safe sex.

Yes No
 Yes No
 Yes No
 Yes No
 Yes No N/A

Please check all that apply:

Touched others sexually without their permission
 Deviant sexual interests Sexual preoccupation Sexually explicit talk
 Exposed self to others Sexually aggressive Masturbation in presence of others
 Received serious consequences due to sexual behaviors (i.e. school expulsion/suspension, legal /social services involvement). Please explain: _____

Acts out sexually with / toward:

Same age peers Younger Older Parents Siblings
 Opposite sex Same sex Both male and female Animals

12. ELOPEMENT (History of Running Away):

Patient is an Elopement Risk. No Yes: High Risk Moderate Risk Low Risk
If Yes, Please Explain: _____

13. BEREAVEMENT:

The patient has experienced a recent loss (through death, divorce, etc.). No Yes, explain: _____

Name of person and relationship: _____
Age of the patient at time of loss: _____
How has this loss affected the patient? _____

There are cultural/religious/ethnic factors affecting patient's bereavement process:
 No Yes, explain: _____
Patient's current illness is affected by the loss. No Yes, explain: _____

Patient is involved in community bereavement resources. No Yes, describe: _____

14. CULTURAL INFLUENCES, RELIGIOUS BACKGROUND, AND CURRENT ACTIVITY:

Patient has a religious affiliation: No Yes : _____
Patient attends religious services. No Yes, name of church/temple: _____

Patient's affiliation with a place of worship is part of his/her support system. No Yes, explain: _____

Patient's current illness has affected his/her spiritual life. No Yes, explain: _____

Patient and family's cultural/ethnic background: _____
The family has specific cultural/ethnic/religious factors that should be considered during treatment.
 No Yes, explain: _____

PATIENT NAME: _____

(Place name label here)

15. **MEDICATIONS:** N/A or
List current medications

Dosage/Frequency

Please check all medications that your child has taken in the past:

ANTI-DEPRESSANTS	STIMULANTS	ANTI-PSYCHOTICS	
Adapin (Doxepin)	Adderall	Abilify (Aripiprazole)	
Anafranil (Clomipramine)	Adderall XR	Clozaril (Clozapine)	
Celexa (Citalopram)	Concerta (Methylphenidate)	Geodon (Ziprasidone)	
Cymbalta (Duloxetine)	Dexedrine	Haldol (Haloperidol)	
Desyrel (Trazodone)	Dexedrine Spansule	Mellaril (Thioridazine)	
Effexor XR (Venlafaxine)	Metadate CD	Orap (Pimozide)	
Elavil (Amitriptyline)	Ritalin (Methylphenidate)	Risperdal (Risperidone)	
Lexapro (Escitalopram)	Ritalin LA	Seroquel (Quetiapine)	
Luvox (Fluvoxamine)	Ritalin SR	Thorazine (Chlorpromazine)	
Norpramin (Desipramine)		Zyprexa (Olanzapine)	
Pamelor (Nortriptyline)	MOOD STABILIZERS		
Paxil (Paroxetine)	Depakote (Valproic Acid)	BENZODIAZEPINES	
Prozac (Fluoxetine)	Depakote ER	Ativan (Lorazepam)	
Remeron (Mirtazapine)	Lithium (Eskalith, Lithobid)	Klonopin (Clonazepam)	
Serzone (Nefazadone)	Lamictal (Lamotrigine)	Xanax (Alprazolam)	
Sinequan (Doxepin)	Neurontin (Gabapentin)		
Tofranil (Imipramine)	Tegretol (Carbamazepine)	SLEEP AIDES	
Wellbutrin (Bupropion)	Topamax (Topiramate)	Ambien (Zolpidem)	
Wellbutrin SR	Trileptal (Oxcarbazepine)	Provigil (Modafinil)	
Wellbutrin XL		Restoril (Temazepam)	
Zoloft (Sertraline)	ANTI CONVULSANTS	Sonata (Zaleplon)	
	Gabitril (Tiagabine)		
ANTIHISTAMINES	Keppra (Levetiracetam)	OTHER	
Benadryl (Diphenhydramine)	Zonegran (Zonisamide)	Amantadine (Symmetrel)	
Vistaril (Hydroxyzine)		Cogentin (Benztropine)	
	SUPPLEMENTS	Strattera (Atomoxetine)	
ANTI-HYPERTENSIVES			
Clonidine (Catapres)			
Inderal (Propranolol)			
Tenex (Guanfacine)			

Please describe any adverse side effects, allergic reactions, medication ineffectiveness and any other significant information regarding any of the above medications:

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16. HISTORY OF PREVIOUS TREATMENT:

Inpatient hospitalization, residential treatment, or partial hospitalization:

No Yes, specify:

Name of facility	Dates of treatment	Sending record to Meridell	Treatment results
		Yes No	Positive Negative None
		Yes No	Positive Negative None
		Yes No	Positive Negative None
		Yes No	Positive Negative None

Outpatient Therapy:

No Yes, specify:

Provider	Phone #	Dates of treatment	Sending record to Meridell	Treatment results
			Yes No	Positive Negative None
			Yes No	Positive Negative None
			Yes No	Positive Negative None
			Yes No	Positive Negative None

17. INITIAL TREATMENT GOALS:

As identified by the patient:

- a. _____
- _____
- b. _____
- _____
- c. _____
- _____

As identified by the family:

- a. _____
- _____
- b. _____
- _____
- c. _____
- _____

18. OUTPATIENT PROVIDERS:

- I am satisfied with our family's current outpatient mental health providers.
- I would like assistance identifying new outpatient mental health providers for our family.

Completed By **Relationship to Patient** **Email Address** **Date**