

EDUCATIONAL PLANNING AND COUNSELING SERVICES

ACUTE CARE YOUNG ADULT ASSESSMENT FOR PHYSICIANS

THANK YOU FOR TAKING THE TIME TO COMPLETE OUR ASSESSMENT

PATIENT NAME: _____ AGE _____

GRADE COMPLETED: _____ VOCATION _____

AGE PATIENT HAD PROBLEM: _____ WHERE YOU TREATING THEM _____

WHO WAS THE PHYSICIAN:

SOCIAL SECURITY BENEFITS _____ YES _____ NO _____ AMOUNT RECEIVING _____ DATE OF RECEIPT _____

WHO MANAGES THIS YOUNG ADULT'S FINANCES _____ PARENTS _____ RELATIVE _____ OTHER GUARDIAN _____

DESCRIBE:

CURRENT LIVING ARRANGEMENT: _____ LIVES WITH PARENTS OR PARENT _____ LIVES ALONE _____ NOT SURE _____ POSSIBLY HOMELESS _____

WHAT SUPPORT SYSTEM IS IN PLACE FOR THIS YOUNG ADULT? (CHECK ALL THAT APPLY)

_____ FAMILY _____ FRIENDS: DESCRIBE IN MORE DETAIL _____

CHURCH FAMILY _____ NEIGHBORS _____

FAMILY OUTSIDE THE COUNTRY _____ PEERS _____

CITY/STATE/COUNTRY _____ CITIZENSHIP _____

CURRENT GRADES ARE _____ EXCELLENT _____ AVERAGE _____ GOOD _____ POOR _____ FAILING

DOES THE YOUNG ADULT ATTEND COLLEGE OR JUNIOR COLLEGE STATUS: FULL TIME: _____

STATUS: FRESHMAN _____ SOPHOMORE _____ JUNIOR _____

SENIOR _____ GRADUATE STUDENT _____

PART TIME _____ WHAT COLLEGE _____

CITY STATE _____

BRIEFLY DESCRIBE: THE MOST RECENT BEHAVIOR OF THE CHILD?

BRIEFLY DESCRIBE: WHETHER THEY ARE ON MEDICATION OR RECEIVE MEDICAL ATTENTION? DO THEY HAVE A PRIMARY DIAGNOSIS AND PHYSICIAN WHO? NAME AND ADDRESS PLEASE!

DESCRIBE?

HOW LONG HAS THIS ADULT HAVING PROBLEMS? WHEN WERE THEY HOSPITALIZED?

ARE YOU THE LEGAL GUARDIAN ____ YES ____ NO

WHO IS THE GUARDIAN _____

DESCRIBE IN DETAIL WHAT STEPS YOU HAVE TAKEN TO ENCOURAGE INDEPENDENT LIVING:

BRIEFLY: TELL US WHAT HAPPEN?

WHAT CONCERNS DO YOU HAVE SINCE THEIR LAST HOSPITALIZATION?

BRIEFLY DESCRIBE THEIR MOST RECENT EPISODE?

WHO HAD TO INTERVENE?

___THERAPIST _____LOCAL POLICE OR LAW ENFORCEMENT _____TRANSPORT
COMPANY _____FAMILY AND FRIEND _____ NEIGHBORS _____ OTHER
PROFESSIONALS _____TYPE OF PROFESSIONAL_____

HOW WOULD YOU CONSIDER YOU CURRENT CONDITION WITH YOUR YOUNG ADULT?

SEVERE IMPAIRMENT _____MODERATELY IMPAIRED _____ MILDLY IMPAIRED _____
_____UNMANAGEABLE

DESCRIBE:

WAS THE DISABILITY IDENTIFIED BY THE HOSPITAL? MENTAL ILLNESS _____

OTHER IMPAIRMENT_____

COGNITIVELY IMPAIRED _____ PHYSICAL IMPAIRED _____ MENTAL IMPAIRMENT
_____SENSORY IMPAIRED _____OTHER IMPAIRMENT:

DESCRIBE: _____

ARE YOU RECEIVING ANY ACCOMMODATIONS TO ADDRESS THIS PROBLEM? THROUGH A
STATE OR LOCAL AGENCY (HEALTH CARE OR SOCIAL SERVICES) _____YES _____NO

WHAT SERVICES _____

IS THE ADULT LEGALLY EMANCIPATED _____YES _____NO

HAS YOUR YOUNG ADULT EVER RECEIVED MENTAL HEALTH SERVICES? WHERE, AND
WHEN?

HAS YOUR CHILD EVER BEEN ADMITTED INTO A RESIDENTIAL TREATMENT FACILITY?

YES _____NO _____ DATE _____YEAR?

WHAT DO YOU BELIEVE WERE THE CHALLENGES OVERLOOKED BY ANY OF THE AGENCIES
OR MEDICAL STAFF?

HOW HAVE YOU BEEN HANDLING THESE CHALLENGES?

DO YOU BELIEVE THERE IS A NEED FOR AN ADDITIONAL MEDICAL OR MENTAL HEALTH PROFESSIONAL?

WOULD YOU CONSIDER THE ADVICE OF ANOTHER PROFESSION REGARDING LONG TERM PLACEMENT?

WOULD COST BE A DETERMINING FACTOR _____ YES _____ NO _____ MAYBE _____ PERHAPS?

EXPLAIN: _____

HAVE YOU DISCUSSED YOUR CONCERNS WITH YOUR YOUNG ADULT?

WHAT HAS BEEN THEIR RESPONSE?

PLEASE FAX OR SEND TO US VIA EMAIL THE ANY TRANSCRIPTS OR SCHOOL RECORDS TO OUR EMAIL, WHICH IS INFO@EDUCATIONAL-PLANNING-AND-COUNSELING.ORG

WHAT IS YOUR YOUNG ADULT'S INTELLECTUAL QUOTIENT? IQ _____?

WHAT WERE THE RESULTS: (IF NOT TAKEN PUT NONE)

SCORES:

RESULTS: _____

FINDINGS: _____

BRIEFLY TELL US WHETHER YOUR PLANS FOR HOSPITALIZATION HAVE BEEN DIFFICULT TO IMPLEMENT?

NEEDS HAVE BEEN ADDRESSED _____ NOT ADDRESSED _____ NEED MORE INFORMATION _____

TO YOUR KNOWLEDGE HAS YOUR CHILD EVER USE OR EXPERIMENTED WITH DRUGS

____ YES ____ NO

EXPLAIN IN DETAIL:

HAS THERE BEEN ANY RELAPSE OR USE OF DRUGS RECENTLY

IF THE ADULT DOES NOT HAVE ANY SUBSTANCE ABUSE ISSUES, ARE THERE ANY MENTAL HEALTH ISSUE NOT MENTIONED:

DESCRIBE _____

EXPLAIN:

HAS YOUR CHILD EVER EXPERIENCED ANY TRAUMA OR EVENT WHICH HAS CAUSED YOU CONCERN? (LOSS OF FAMILY MEMBER, MOVED, CHANGE IN SCHOOLS)

DATE OF THE EVENT: _____ YEAR _____

HAS YOUR CHILD ENGAGED IN SELF DESTRUCTIVE BEHAVIOR? (PARANOID THINKING, SUSPICIOUS BEHAVIOR LYING, THREATENING OTHERS, RUNNING AWAY)?

DESCRIBE YOUR CHILD'S LEVEL OF CONFIDENCE OR SELF ESTEEM?

DOES YOUR CHILD HAVE ANY LEARNING DIFFERENCES

DESCRIBE: _____

DOES YOUR CHILD HAVE AUTISM _____ YES _____ ON THE SPECTRUM HOW SEVERE IS THE CONDITION.

_____ VERY SEVERE _____ MODERATE _____ SOMEWHAT SEVERE _____ VERY SEVERE

IS YOUR CHILD TAKING ANY MEDICATION OR RECEIVING MEDICAL ATTENTION?

WHAT IS THE NATURE OF THEIR CONDITION? (AGITATED, RESTLESS, NOT SLEEPING, AND NOT EATING)

HOW LONG HAVE THEY BEEN IN THIS CONDITION? WHAT CARE WAS RECEIVED? WHERE?

WHO WAS THE DOCTOR: _____

MAY WE CONTACT THEM?

YES _____ NO _____

ADDRESS

CITY/STATE/COUNTRY

WOULD YOU DESCRIBE YOUR CHILD'S OVERALL HEALTH AS?

_____ EXCELLENT _____ GOOD _____ NOT SO GOOD _____ VERY POOR

WHERE WOULD YOU BE MOST COMFORTABLE IN PLACING YOU CHILD AFTER LEAVING A THERAPEUTIC OR WILDERNESS?

_____ PUBLIC SCHOOL _____ PRIVATE SCHOOL _____ BOARDING SCHOOL

_____ CHARTER SCHOOL _____ VOCATIONAL SCHOOL _____ COLLEGE

AGREEMENT

BY GIVING CONSENT THE PARENT SIMPLY AGREES TO ALLOW THE EDUCATIONAL CONSULTANT TO WORK ON BEHALF OF THE FAMILY IN A PLACEMENT OR SCHOOL OR PROGRAM.

PARENT SIGNATURE

FULL NAME/PLEASE PRINT

ARE YOU THE LEGAL GUARDIAN OR PARENT _____ YES _____ NO?

WHO IS THE LEGAL GUARDIAN _____?

DO YOU HAVE JOINT CUSTODY? _____

ADDRESS

CITY/STATE/COUNTRY/

KENNETH DAVIS MA ED EDUCATIONAL CONSULTANT

DATE/MONTH/YEAR COMPLETED ASSESSMENT

PLEASE FAX THE FORM TO OUR FAX: 623 322-9481