TANAGER PLACE
YOUR CHILD : OUR FOCUS

I have enclosed the application for admission to our Inpatient Program. In this envelope you will find the following documents that must be returned before we can make a determination.

- ☐ Client Face Sheet, page 2
- ☐ Medical History, page 3 and 4
- ☐ Symptom Checklist, page 5 and 6
- ☐ Social History, page 7 and 8
- ☐ Social History Part II: Life Events Checklist, page 9

You will also find a blank Consents to Release and Exchange Information allowing current or past providers to share information about the child. Refer to the sample ROI that has also been provided for instructions on completing.
Note: *If the child receives multiple services and sees multiple providers at the same agency then you only need 1 release for that agency. However, if the child sees multiple providers at different agencies then a release needs to be filled out for each agency that the child receives services at.*

The following consents will need returned, if not applicable please indicate such in the table below:

Med Manager/Psychiatrist	☐ Consent Completed	☐ Not applicable
Psychologist/Psychological Testing	☐ Consent Completed	☐ Not applicable
Therapist	☐ Consent Completed	☐ Not applicable
Group Therapy [DBT, Life Program, Intensive Outpatient]	☐ Consent Completed	☐ Not applicable
BHIS	☐ Consent Completed	☐ Not applicable
PIH/IHH	☐ Consent Completed	☐ Not applicable
Hospital	☐ Consent Completed	☐ Not applicable
DHS	☐ Consent Completed	☐ Not applicable
JCS	☐ Consent Completed	☐ Not applicable
Attorney or GAL	☐ Consent Completed	☐ Not applicable
School	☐ Consent Completed	☐ Not applicable
MCO Case Manager	☐ Consent Completed	☐ Not applicable
Other:	☐ Consent Completed	☐ Not applicable

If you have records already, please include them when returning your admission packet. You may give the forms to providers who can fax or mail information to the Admissions Office. You may also return everything to the Admissions Office for processing.

We will be in contact with you after records have been received and reviewed by our clinical team. At this point we will determine if our program is appropriate for the child or we will make recommendations for other services.

Additional information can be found on our website at www.tanagerplace.org. Please feel free to contact me with any questions.

Sincerely,

Jenn Hodgden
Inpatient Authorization Coordinator
Ph: 319-365-9165 x330
jhodgden@tanagerplace.org

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CLIENT FACE SHEET

TANAGER PLACE
YOUR CHILD · OUR FOCUS

Client Information

First Name: _____ **MI:** _____ **Last Name:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Work Phone:** (_____)_____

Email Address (Parent/Guardian): _____

Client's Date of Birth: _____ _____ **Gender:** ☐ Male ☐ Female

Height: _____ **Weight**: _____ **Hair-color:** _____

Race: ☐ White ☐ African American ☐ Asian ☐ Bi-Racial ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ African

Caregiver/Emergency Contact Information ☐ is legal Guardian

Name: _____ **Relationship to Client:** _____ ☐ **Same Info. Above**

Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Email:**_____

Individual Financially Responsible for Account ☐ is legal Guardian

Name: _____ **Relationship to Client:** _____ ☐ **Same Info. Above**

Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Email:**_____

Does the child receive any of the following insurance coverage or benefits?

☐ IME ☐ Iowa Total Care ☐ Amerigroup ☐ Other: Policy ID:

Primary Commercial/Private Insurance

Insurance Company: _____

Insurance ID:_____ Group#_____

Relationship to Insured: ☐ Child ☐ Spouse ☐ Self ☐ Other

Subscriber information:

Name: _____

DOB: _____ Gender: ☐ Male ☐ Female

Address: _____

Phone #: (_____) _____

Employer:_____

Secondary (if applicable)

Insurance Company: _____

Insurance ID: _____ Group#_____

Relationship to Insured: ☐ Child ☐ Spouse ☐ Self ☐ Other

Subscriber information:

Name: _____

DOB: _____ Gender: ☐ Male ☐ Female

Address: _____

Phone #: (_____) _____

Employer:_____

Additional Benefit Information

☐ Social Security Benefits $ amount per month:_____

☐ Child Support $ amount per month:_____

☐ Adoption Subsidy $ amount per month:_____

If your child receives income, you will be required to pay some or all of these amounts towards the cost of your child's care.

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MEDICAL HISTORY

TANAGER PLACE
YOUR CHILD : OUR FOCUS

First Name: _____ MI: _____ Last Name: _____DOB: _____
Allergies ☐ No known Allergies List drugs, food, latex, other and reaction: _____
Immunizations up to date? ☐ Yes ☐ No If no, explain: _____

Has your child had a history of, or any problems, with any of the following:

Seizures/Epilepsy	☐ Yes	☐ No	Muscle/Bone/Joint Issues	☐ Yes	☐ No
Tremors	☐ Yes	☐ No	Nosebleeds	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Ear Tubes	☐ Yes	☐ No
- Use inhaler?	☐ Yes	☐ No	Hearing impaired	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	- Use hearing aids?	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Menstruation Issues	☐ Yes	☐ No
Congenital Heart Problems	☐ Yes	☐ No	Current pregnancy	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No	Sexually Transmitted Diseases	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	HIV/AIDs	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Cancer or Radiation treatment	☐ Yes	☐ No
Constipation/Diarrhea	☐ Yes	☐ No	MRSA	☐ Yes	☐ No
GERD/Acid Reflux	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No
Eating Disorders	☐ Yes	☐ No	Meningitis	☐ Yes	☐ No
Urinary Tract Infection	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No	Bleeding problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Hepatitis or Liver Disease	☐ Yes	☐ No
Skin Issues [Eczema, Psoriasis, etc.)	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No

If yes to any above explain:

_____

_____

_____

Speech Therapy, Occupational Therapy, Physical Therapy? ☐ Yes ☐ No
Physical limitations that impact ability to bathe or toilet independently? If yes, explain:
_____ ☐ Yes ☐ No
Special Dietary Accommodations? ☐ Yes ☐ No
Hygiene: ☐ Poor ☐ Fair ☐ Good
Any recent diagnostic testing [EKG, Ultrasound, Lab, x-ray]? ☐ Yes ☐ No
Any other medical history not listed above: _____

Family Medical History *[please indicate below family history of, or problems, with the following]*

	Mother	Father	Aunt	Uncle	Grandmother	Grandfather	Sibling
Heart Problems	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Genetic/Inheritable Conditions	☐	☐	☐	☐	☐	☐	☐
Chronic Illness	☐	☐	☐	☐	☐	☐	☐
Other:							

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Surgical History/Hospitalization:		
Date	**Reason/Type**	**Comment**

Medication bottles or prescriptions from medication provider have been provided to admissions? ☐ Yes ☐ No

Medical Providers

Primary Care Physician [PCP] ☐ no current

Name: _____ **Office Name:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____)_____ **Date of last visit:** _____ **Next Appointment:** _____

Dentist ☐ no current

Name: _____ **Office Name:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____)_____ **Date of last visit:** _____ **Next Appointment:** _____

Has antibiotic medicine been required before dental treatment? ☐ Yes ☐ No

Current toothache, sores, or swelling in the mouth? ☐ Yes ☐ No

Other dental problems? ☐ Yes ☐ No

Requires help with tooth brushing? ☐ Yes ☐ No

Thumb, finger, or pacifier sucking? ☐ Yes ☐ No

If yes, please explain: _____

_____

Orthodontist / Clinic ☐ no current

Name: _____ **Office Name:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____)_____ **Date of last visit:** _____ **Next Appointment:** _____

Please explain condition and treatment provided: _____

_____

Vision [optometrist] ☐ no current

Name: _____ **Office Name:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____)_____ **Date of last visit:** _____ **Next Appointment:** _____

Does the child have glasses or contacts? ☐ Yes ☐ No

If yes, how often are they worn? _____

Are glasses/contacts with the child here? ☐ Yes ☐ No

Other [PT/OT/Speech] ☐ no current

Name: _____ **Office Name:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Phone #: (_____)_____ **Date of last visit:** _____ **Next Appointment:** _____

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SYMPTOM CHECKLIST

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Name: _____ MI: _____ Last Name: _____DOB: _____

INSTRUCTIONS: *INDICATE PRESENCE OF EACH PROBLEM OR SYMPTOM, WITH LEVEL OF OCCURRENCES FROM NEVER TO ALWAYS*

	Never	Rarely	Sometimes	Often	Always
Physical Aggression	☐	☐	☐	☐	☐
Verbal Aggression	☐	☐	☐	☐	☐
Destruction of property	☐	☐	☐	☐	☐
Agitation	☐	☐	☐	☐	☐
Argues	☐	☐	☐	☐	☐
Fights with others	☐	☐	☐	☐	☐
Quick to anger	☐	☐	☐	☐	☐
Meltdowns	☐	☐	☐	☐	☐
Avoidant	☐	☐	☐	☐	☐
Cruelty towards animals	☐	☐	☐	☐	☐
Non-compliant	☐	☐	☐	☐	☐
Fire Setting	☐	☐	☐	☐	☐
Runs away	☐	☐	☐	☐	☐
Lying	☐	☐	☐	☐	☐
Absent from school	☐	☐	☐	☐	☐
Takes unnecessary risks	☐	☐	☐	☐	☐
Sexualized behavior	☐	☐	☐	☐	☐
Regressive Behaviors	☐	☐	☐	☐	☐
Difficulty with change	☐	☐	☐	☐	☐
Difficulty coping	☐	☐	☐	☐	☐
Indiscriminate affection with strangers and others	☐	☐	☐	☐	☐
Clingy with parent	☐	☐	☐	☐	☐
Difficulty with parental absence	☐	☐	☐	☐	☐
Does not go to parent for comfort	☐	☐	☐	☐	☐
Will not accept closeness or comfort	☐	☐	☐	☐	☐
Acute jealousy towards siblings	☐	☐	☐	☐	☐
Bossy toward others	☐	☐	☐	☐	☐
Teases others	☐	☐	☐	☐	☐
Is down on him or herself	☐	☐	☐	☐	☐
Acts younger than children his or her age	☐	☐	☐	☐	☐
Does not show feelings	☐	☐	☐	☐	☐
Does not understand other people's feelings	☐	☐	☐	☐	☐
Blames others for his or her troubles	☐	☐	☐	☐	☐
Difficulties with peers	☐	☐	☐	☐	☐
Frequent visits to the Dr.	☐	☐	☐	☐	☐
Flashbacks	☐	☐	☐	☐	☐
Weight concerns	☐	☐	☐	☐	☐
Body image distortion	☐	☐	☐	☐	☐
Negative Self Talk	☐	☐	☐	☐	☐
Negative view of self	☐	☐	☐	☐	☐
Nutritional concerns	☐	☐	☐	☐	☐
Nightmares	☐	☐	☐	☐	☐
Difficulty falling asleep	☐	☐	☐	☐	☐
Difficulty staying asleep	☐	☐	☐	☐	☐
Oversleeping	☐	☐	☐	☐	☐

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Continued…	Never	Rarely	Sometimes	Often	Always
Lack of sleep	☐	☐	☐	☐	☐
Obsessions	☐	☐	☐	☐	☐
Compulsions	☐	☐	☐	☐	☐
Hoarding behaviors	☐	☐	☐	☐	☐
Afraid of new situations	☐	☐	☐	☐	☐
Excessive fears	☐	☐	☐	☐	☐
Racing Thoughts	☐	☐	☐	☐	☐
Reactive	☐	☐	☐	☐	☐
Restless	☐	☐	☐	☐	☐
Rigidity	☐	☐	☐	☐	☐
Tense	☐	☐	☐	☐	☐
Nervous	☐	☐	☐	☐	☐
Worries excessively	☐	☐	☐	☐	☐
Tics	☐	☐	☐	☐	☐
Tremors	☐	☐	☐	☐	☐
Concentration problems	☐	☐	☐	☐	☐
Fails to complete tasks	☐	☐	☐	☐	☐
Fidgety	☐	☐	☐	☐	☐
Low frustration tolerance	☐	☐	☐	☐	☐
Hyperactive	☐	☐	☐	☐	☐
Impulsive	☐	☐	☐	☐	☐
Irritable	☐	☐	☐	☐	☐
Procrastinates	☐	☐	☐	☐	☐
Crying Spells	☐	☐	☐	☐	☐
Prolonged sadness	☐	☐	☐	☐	☐
Helpless	☐	☐	☐	☐	☐
Hopeless	☐	☐	☐	☐	☐
Isolated	☐	☐	☐	☐	☐
Withdrawn	☐	☐	☐	☐	☐
Loss of energy	☐	☐	☐	☐	☐
Loss of interest	☐	☐	☐	☐	☐
Complains of aches and pains	☐	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐	☐
Tires easily	☐	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	☐
Grandiose thinking	☐	☐	☐	☐	☐
Paranoia	☐	☐	☐	☐	☐
Enuresis (wetting accidents)	☐	☐	☐	☐	☐
Encopresis (soiling accidents)	☐	☐	☐	☐	☐
Other abnormal bathroom behaviors	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐
Drug	☐	☐	☐	☐	☐
Prescription Pill Abuse	☐	☐	☐	☐	☐
Gambling	☐	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐	☐
Technology	☐	☐	☐	☐	☐
Non Suicidal Self Injury [NSSI}	☐	☐	☐	☐	☐
Suicidal	☐	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐	☐

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SOCIAL HISTORY

Client Name: _____ MI: _____ Last Name: _____DOB: _____

I. CLIENT INFORMATION

Mental Health History

Service History:	
Diagnosis History:	
Hospitalization History:	
Medication History:	
Current Medication/ Prescriber:	

Physical/Medical History

Current Issues:	
Past Issues:	
Surgeries:	
Known Allergies:	
Current Treating Physician:	

EARLY CHILDHOOD/ DEVELOPMENTAL HISTORY	YES	NO	COMMENTS
Did client's mother receive proper prenatal care?	☐	☐	
Was the client exposed to substances in utero?	☐	☐	
Were there complications during pregnancy or with client's birth?	☐	☐	
Did client or caregiver require special attention in first few weeks or months of life?	☐	☐	
Were developmental milestones met within normal time span?	☐	☐	
In the first 5 years of life:			
As a baby, was your client difficult to sooth or comfort?	☐	☐	
Did your client have frequent, intense temper tantrums or mood changes?	☐	☐	
Did your client have a difficult time adapting to places or people?	☐	☐	
Did your client engage in self-injurious behaviors?	☐	☐	
Was your client alert to their environment?	☐	☐	
Did your client interact with others?	☐	☐	

RISK ASSESSMENT	RECENT/ CURRENT	PAST	NONE / NA	COMMENTS
Alcohol	☐	☐	☐	
Drugs	☐	☐	☐	
Prescription Pills	☐	☐	☐	
Gambling	☐	☐	☐	
Nicotine	☐	☐	☐	
Pornography/Sex	☐	☐	☐	
Technology	☐	☐	☐	
Non Suicidal Self Injury (NSSI)	☐	☐	☐	
Suicidal	☐	☐	☐	
Homicidal	☐	☐	☐	
Aggression	☐	☐	☐	
Sexual	☐	☐	☐	

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RESILIENCE ASSESSMENT	COMMENTS
Who are trusted adults or social supports in the client's life?	
What are the norms that are important to the client/ values?	
What are the client's abilities and strengths?	
What are the client's hobbies or leisure activities?	
What are the client's aspirations or goals in life?	
What does the client do to take care of themselves?	

II. Client Psychosocial, Behavioral, Environmental & Social Functioning

Employment

Current Employment:	
Employment History:	

Education

Current/Highest Grade:	
Current School:	
School History:	
IEP/ 504 Plan:	
Attendance:	
Academic Functioning:	
Extracurricular Activities:	

Cultural

Cultural Considerations:	
Religious/Spiritual Beliefs:	

III. FAMILY INFORMATION

Name	Relationship and Status (excellent, good, fair, poor, estranged)

Other significant relationships:

	Relationship and Status (excellent, good, fair, poor, estranged)

Who all lives in client's home? ☐ Father ☐ Mother ☐ Siblings [specify ages: _____]
☐ Other: _____

Family History of Mental Health:

Father	☐Current ☐Past ☐None	Describe Treatment:
Mother	☐Current ☐Past ☐None	Describe Treatment:
Sibling(s)	☐Current ☐Past ☐None	Describe Treatment:
Other	☐Current ☐Past ☐None	Describe Treatment:

Family History of Substance Abuse:

Father	☐Current ☐Past ☐None	Describe Treatment:
Mother	☐Current ☐Past ☐None	Describe Treatment:
Sibling(s)	☐Current ☐Past ☐None	Describe Treatment:
Other	☐Current ☐Past ☐None	Describe Treatment:

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SOCIAL HISTORY PART II: LIFE EVENTS CHECKLIST

Client Name: _____ MI: _____ Last Name: _____DOB: _____

Please indicate current, past, or none for the following items listed:

LIFE EVENTS	RECENT	PAST	NONE / NA	COMMENTS
Death of a family member	☐	☐	☐	
Neighborhood violence	☐	☐	☐	
Victim of crime/violence	☐	☐	☐	
Bystander of crime/violence	☐	☐	☐	
Victim of bullying	☐	☐	☐	
Victim of a fire	☐	☐	☐	
Caregiver separation/divorce	☐	☐	☐	
Incarceration of Parent or Sibling	☐	☐	☐	
Illness of Family Member	☐	☐	☐	
Abuse of drugs/alcohol by family member	☐	☐	☐	
Victim of natural disaster	☐	☐	☐	
Utilities shut off	☐	☐	☐	
Frequent moving	☐	☐	☐	
Homelessness	☐	☐	☐	
Significant illness	☐	☐	☐	
Significant accident/injury	☐	☐	☐	
Require Special Medical Attention	☐	☐	☐	
Death or illness of classmate/school support	☐	☐	☐	
Involuntary school transfer	☐	☐	☐	
Coming out LGBTQ	☐	☐	☐	
Refugee/Immigrant	☐	☐	☐	
Mental Health of a family member	☐	☐	☐	
Deportation of a family member or loved one	☐	☐	☐	
Loss of pets	☐	☐	☐	
Frequent change in caregiver/daycare provider	☐	☐	☐	
Adoption	☐	☐	☐	
Separation from primary caregiver	☐	☐	☐	
Domestic Violence	☐	☐	☐	
Sexual Abuse	☐	☐	☐	
Physical Abuse	☐	☐	☐	
Emotional/Mental Abuse	☐	☐	☐	
Neglect/Denial of Critical Care	☐	☐	☐	
Exposure to explicit material	☐	☐	☐	
Exposure to substances or violence utero	☐	☐	☐	
Complications during pregnancy or birth	☐	☐	☐	

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