Dear Patient and Family,

Thank you for your interest in the Clinic for Interactive Media and Internet Disorders (CIMAID) at Boston Children’s Hospital. **Please read all of the information below regarding our clinic.** Please initial in each box below each bullet point to indicate your understanding.

1. CIMAID is a short-term consultation clinic, with the goal of establishing a treatment plan that can be implemented by your child’s current provider. Your child can expect to have one or several appointments in which they will establish a safe treatment environment, and receive:
	1. An extensive evaluation to determine whether your child has problematic interactive media use (PIMU)
	2. Recommendations for treatment, which may include medication, therapy, and/or consultation with your child’s current doctors/therapists
	3. Guidance on establishing clear rules/expectations around media use
	4. Guidance on other individual and family issues that may be affecting your child’s media use

I have read and understand the above: [ ]

1. Our clinic sees new patients on Tuesday mornings and returning patients on Tuesday afternoons.

I have read and understand the above: [ ]

1. If the above program terms suit your needs, please complete the following intake form. If you are looking for something else or have questions, please feel free to give us a call 617-355-9447 or email cimaid@childrens.harvard.edu

I have read and understand the above: [ ]

1. Boston Children's Hospital is a teaching hospital, and we allow trainees to observe patient/doctor interactions. The general purpose of an Observership is to watch and listen only with no patient contact and no research activity. Observerships are undertaken solely for the purposes of gaining knowledge. If at any point you want the observer to leave, you can say so during the appointment, and the observer will leave immediately. Please indicate if you would be comfortable with having an observer for your upcoming CIMAID appointment.

 I am comfortable with having an observer: [ ]

Sincerely,

Clinic for Interactive Media and Internet Disorders

**Boston Children’s Hospital Clinic for Interactive Media and Internet Disorders Intake Form**

Instructions:

* Please answer all questions, leaving no blanks. Write “N/A” if the question isn’t applicable.
* With any questions regarding this intake form, please email cimaid@childrens.harvard.edu or call 617-355-9447
* If you would prefer to complete this intake over the phone, please call 617-355-9447. Please do not print this form and hand-write answers – we are only able to accept typed responses.
* Please return this completed form to cimaid@childrens.harvard.edu or via the MyChildren’s Patient Portal.

|  |  |
| --- | --- |
| Today’s date | Click or tap here to enter text. |

**Patient Information and Demographics**

|  |  |
| --- | --- |
| Patient name | Click or tap here to enter text. |
| Date of birth | Click or tap here to enter text. |
| Current age | Click or tap here to enter text. |
| If your child is over the age of 18, or will be turning 18 within the next 3 months, they must sign a release of information form in order to be seen in our clinic. Contact cimaid@childrens.harvard.edu to request the form. |
| Address (street, apt #) | Click or tap here to enter text. |
| Address (city, state, zip) | Click or tap here to enter text. |
| Assigned sex at birth | Click or tap here to enter text. |
| Gender identity | Click or tap here to enter text. |
| Pronouns *(Examples: she/her/hers, he/him/his, they/them/theirs, etc.)* | Click or tap here to enter text. |
| Race/ethnicity *(may include multiple)* | Click or tap here to enter text. |
| Primary language | Click or tap here to enter text. |
| Interpreter needed? | Click or tap here to enter text. |

**Parent/Guardian Information**

**Parent/Guardian 1**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Phone | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Relationship to patient | Click or tap here to enter text. |

**Parent/Guardian 2**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Phone | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Relationship to patient | Click or tap here to enter text. |

**Other Guardian or Emergency Contact**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Phone | Click or tap here to enter text. |
| Email | Click or tap here to enter text. |
| Relationship to patient | Click or tap here to enter text. |

**Primary Contact**

|  |  |
| --- | --- |
| Which parent/guardian should we contact? | Click or tap here to enter text. |
| What are best times to contact? | Click or tap here to enter text. |

**Insurance and Referral Information**

|  |  |
| --- | --- |
| Insurance plan | Click or tap here to enter text. |
| If you were referred by a medical provider, please provide their name and phone number | Click or tap here to enter text. |
| If you were not referred by a medical provider, how did you learn about us? | Click or tap here to enter text. |

**Current Care Team**

As part of our intake and internal evaluation to determine if care is appropriate within our program, please provide the following information for your current healthcare providers as our clinicians may need to call one or more to discuss your current treatment. By completing this form, you are authorizing us to contact these providers.

|  |  |
| --- | --- |
| Primary care provider and phone number | Click or tap here to enter text. |
| Please list any specialists including specialty area, hospital affiliation, and phone numbers | Click or tap here to enter text. |
| Therapist and phone number | Click or tap here to enter text. |
| Psychiatrist and phone number | Click or tap here to enter text. |
| Are you receiving any integrated or complementary treatment?If so, please provide name(s) and phone number | Click or tap here to enter text. |

**Medical History**

|  |  |
| --- | --- |
| Please list any chronic medical issues such as diabetes, obesity, cancer, etc. | Click or tap here to enter text. |
| Please list any previous or current substance use issues. | Click or tap here to enter text. |

**Medications**

|  |  |
| --- | --- |
| Name | Click or tap here to enter text. |
| Dosage | Click or tap here to enter text. |
| Date Started | Click or tap here to enter text. |
| Date stopped dose | Click or tap here to enter text. |
| Benefits | Click or tap here to enter text. |
| Side effects | Click or tap here to enter text. |

**Mental Health Issues**

|  |  |
| --- | --- |
| Please list all diagnosed mental health conditions | Click or tap here to enter text. |
| Please list all past psychiatric hospitalizations, admissions to partial hospital programs (PHP), or admission to intensive outpatient programs (IOP) | Click or tap here to enter text. |
| Please list all current and previous participation in therapy and/or counseling including dates and reasons. | Click or tap here to enter text. |
| Have any other family members been diagnosed with mental health issues? | Click or tap here to enter text. |

**Educational History**

|  |  |
| --- | --- |
| School | Click or tap here to enter text. |
| Grade | Click or tap here to enter text. |
| Please describe whether the patient has any learning difficulties | Click or tap here to enter text. |
| Please describe any accommodations, such as an IEP or 504 plan | Click or tap here to enter text. |

**Reason for Seeking Care**

**Please provide a brief explanation of each issue, or enter N/A if not applicable**

**Does your child have any of the following media use issues?**

|  |  |
| --- | --- |
| Gaming | Click or tap here to enter text. |
| Social media | Click or tap here to enter text. |
| Pornography | Click or tap here to enter text. |
| Video bingeing | Click or tap here to enter text. |
| Please provide a brief summary of what has been going on with the patient’s media use | Click or tap here to enter text. |

**Is your child experiencing any of the following issues with their social life?**

|  |  |
| --- | --- |
| Spending less time with friends and family? | Click or tap here to enter text. |
| Spending more time alone? | Click or tap here to enter text. |
| Fighting more with friends and family? | Click or tap here to enter text. |
| Giving up favorite activities or hobbies? | Click or tap here to enter text. |
| Avoiding others? | Click or tap here to enter text. |
| Please provide a brief summary of what has been going on with the patient’s social life | Click or tap here to enter text. |

**Is your child experiencing any of the following issues with school?**

|  |  |
| --- | --- |
| Experiencing a drop in their grades? | Click or tap here to enter text. |
| Missing school? | Click or tap here to enter text. |
| Having trouble paying attention in class? | Click or tap here to enter text. |
| Missing homework or doing poor quality homework? | Click or tap here to enter text. |
| Please provide a brief summary of what has been going on with the patient’s schooling  | Click or tap here to enter text. |

**Does your child have any of the following issues with sleep?**

|  |  |
| --- | --- |
| Going to bed late or waking up in the middle of the night? | Click or tap here to enter text. |
| Sleeping during the day? | Click or tap here to enter text. |
| Having trouble falling asleep at night? | Click or tap here to enter text. |
| Having trouble waking up in the morning? | Click or tap here to enter text. |
| Please provide a brief summary of what has been going on with the patient’s sleep | Click or tap here to enter text. |

**Does your child have any of the following mood issues?**

|  |  |
| --- | --- |
| Anger | Click or tap here to enter text. |
| Aggression | Click or tap here to enter text. |
| Please provide a brief summary of what has been going on with the patient’s mood | Click or tap here to enter text. |

**Does your child have any of the following?**

|  |  |
| --- | --- |
| A diagnoses developmental or intellectual disability? | Click or tap here to enter text. |
| A diagnosis of moderate to severe autism? | Click or tap here to enter text. |
| A history of experiencing hallucinations or psychosis? | Click or tap here to enter text. |

**Summary**

|  |  |
| --- | --- |
| For **parents/guardians** completing this form:What are your **main goals, concerns, or questions** for your child’s participation in the Clinic for Interactive Media and Internet Disorders? | Click or tap here to enter text. |
| Is there anything else that you would like us to know? | Click or tap here to enter text. |
| Would you like to be added to our wait list? | Click or tap here to enter text. |