BEHAVIORAL HEALTH SOLUTIONS, PC – Intake Form

Therapist: ______________________________ Date: _____________________ PTA☐ PE☐ 90847☐ 90806☐

Referral Information

Patient Name: _____________________________________ Nickname: _____________________________________

Home Address: ____________________________________ City: _____________________ State: ___ Zip: ______

Phone #: _________________________ May we contact you at this #? ☐ Yes ☐ No Email:_______________

Primary Care Physician: _____________________________ Phone #: _______________________________________

Who referred you to this clinic?: ____

Reason for referral? *(Please provide a brief description):* ____

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Insurance Coverage (company(s)): ____

Patient's Background Information / Family Dynamics

Date of Birth: _____________ Age: ________________

Ethnicity (circle all that apply): African-American Asian-American Hispanic Native American Caucasian Other:_______

Sex: M F Religious Preference: __________________________________

Patient resides with: Biological Parent(s) Adoptive Parent(s) Foster Parent(s) Legal Guardian(s) Other: _________________

Persons with whom the child is currently residing

Mother's name:______________________________________
(circle one) Biological Step Adoptive Foster/Guardian
Date of Birth: _________________ *(needed for insurance claims)*
Home Phone: ____________ Work Phone: ______________
Place of Employment: ________________________________
Occupation: ____
Work Schedule: ____________________________________

Father's name: ___________________________________
(circle one) Biological Step Adoptive Foster/Guardian
Date of Birth: _________________ *(needed for insurance claims)*
Home Phone: ____________ Work Phone: __________
Place of Employment: _____________________________
Occupation: _____________________________________
Work Schedule: ___________________________________

Other Members Living in Household: (*for example, siblings, step-siblings, niece/nephew, foster children*):

Name Age Sex Relation to patient

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____

Other Regularly Involved Adults (***non-custodial parents & step-parents***/*grandparents/caregivers*)

Name Relation to patient Frequency of Contact

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For foster parents/legal guardians:

Date of placement: ________________________ Reason for placement: ____

Name of child's caseworker: ___________________________________ Phone Number: _____________________________________

Visitation with biological parents? ____ Yes ____ No If yes, frequency of visits ________________ Supervised? ____ Yes ____ No

Is Reunification the permanency goal? ____ Yes ____ No ____ Unknown

Previous residences:

City and State	Length of Time Lived There	Reason for Move

Medical & Developmental Information

Did you and/or your doctor note any problems with pregnancy? Yes _______ No _______

Were there any concerns with drug/alcohol abuse, cigarette use, high blood pressure? Yes _______ No ________

What is your general impression of the child's infant development Good ___ Fair ___ Delayed____

Please indicate when your child achieved the following activities
(either enter age when skill was acquired or if you felt their attainment was in the normal range or delayed):

Sat Alone _________ (average 6 to 8 mos.)
Crawled __________ (average 9 mos.)
Walked ________ (average 12 to 18 mos.)

Fed Self __________ (average 10 to 12 mos.)
Spoke Words ______ (average 10 mos.)
Toilet Trained ________ (average 2 to 3 yrs.)

Does your child have any physical health problems that may interfere with normal functioning (vision, hearing, motor)? Yes_______ No __________

Are there any current health concerns? Yes_______ No __________

If yes, to either of these questions, please briefly describe:

____

____

Medications & Dosage Information: ____

____

Name of physician/psychiatrist managing medications: ____

Has your child received previous counseling? ☐ Yes ☐ No Dates: ___________________________________

Previous counselor(s): ____

Reason for counseling: ____

Previous diagnoses (if known): ____

Please provide any family history of mental health concerns (diagnosed or undiagnosed): __________________________

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Academic & School Information

Currently attends school: Yes______ No ________

Child is currently in the ________ grade

If your appointment time is during summer months...

Attended school last year Yes_______ No________

Child will be entering the __________ grade

Child attends ______________ School

Teacher's Name(s):___________________________________

Child's current grades are: _______________________

Grades last reporting semester were:______________________

Has child ever been suspended, expelled, or retained in a grade? Yes_______ No ________

If yes, please explain: ____

Has child every received any type of educational programming? Yes_______ No ________

(Special Education, Learning Disabilities, Behavioral / Emotional Disorders class, Speech/Language services, Resource Room)

If your child receives special services, which services? ____

Has child completed psycho-educational testing for learning disabilities? Yes_______ No ________

If yes, please explain:____

Does your child have an IEP (Individual Education Plan)? Yes_______ No ________

If yes, under what verification/for what reason? ____

Have behavioral concerns been reported at school? Yes_______ No ________

If yes, please explain: ____

If behavioral/academic concerns are noted, when did they begin?: ____________________________________

Patient/Family Legal Concerns & Issues

Has the child been involved in legal concerns (victim/offender)? Yes_______ No ________

If yes, please explain and provide approximate dates:____

____

Has any member of the child's family been involved in legal concerns (victim/offender)? Yes_______No ________

If yes, please explain and provide approximate dates:____

____

Has the child experienced or is suspected to have experienced any of the following? If yes, please provide brief detail:

Sexual Abuse: ____

Physical Abuse: ____

Neglect: ____

Witness of Violent Act: ____

Is there a history of drug or alcohol use within the family? Please explain: ______________________________

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Other pertinent information: ____

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General Behavioral Information

If any of the following are concerns for your child, please provide a brief description:

- ☐ Oppositional behavior:____
- ☐ Anger/Aggressive behavior: ____
- ☐ Tantrums: ____
- ☐ Change in mood / interest in activities:_______________________________
- ☐ Fears/ unwanted thoughts:____
- ☐ Unusual habits / repetitive behavior: __________________________________
- ☐ Sleep problems/changes: ____
- ☐ Appetite problems/changes: ____
- ☐ Suicidal / homicidal ideation: ____
- ☐ Self harming behaviors: ____
- ☐ Alcohol/drug use: ____
- ☐ Sexual problems:____
- ☐ Abuse (sexual/physical): ____
- ☐ Neglect: ____
- ☐ Self-esteem: ____
- ☐ Adjustment (death/divorce): ____
- ☐ Toileting: ____
- ☐ Attention problems: ____
- ☐ Hyperactivity: ____
- ☐ Relationship problems: ____
- ☐ School problems: ____
- ☐ Other: ____
- ☐ Other: ____

Please identify your child's strengths/hobbies:

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Thank you for providing detailed information regarding your child. This will assist the therapist greatly in understanding your child's and your family's unique needs.

The information provided on this form is for the purposes of behavioral health evaluation and treatment only. The information provided on this form cannot be released without express written permission of the parent or legal guardian of this child. If you have any questions about how this information will be used, please discuss your concerns with your therapist during your first visit.