**A New Tomorrow**

**Behavioral Health Services**

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**Child & Adolescent Intake**

*The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our providers. As you complete this form, feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.*

# General Information:

Date:

Sex: Gender Identity (Optional): Sexual Preference (Optional):

Patient Name:

Date of Birth: Patient’s Social Security Number:

Parent/Guardian:

Home Address:

Street City/State Zip

Home/Primary Phone:

Cell Phone: Mother: Father:

Email:

School: Grade:

School’s Telephone Number:

Teacher(s):

Does client attend special classes at school? yes no

If yes, explain:

Spiritual / Cultural Factors (Optional):

Please Describe Your Child’s Social Interactions:

# Parents/Guardians and Family Information:

Mother’s Name:

Age:

Occupation: Education Completed:

Father’s Name: Age:

Occupation: Education Completed:

Marital Status (circle one): Married Remarried Divorced Separated Widowed Single Cohabitants

**Siblings:** List IN ORDER BY AGE siblings of client.

Sibling Name Age School Grade Year Conduct\*

How would you say the client gets along with their siblings?

**\***(Please indicate good, fair, or poor conduct)

 Great Very Good Good Fair Poor Very Poor

Describe:

List the occupants in the home:

# Family History

Has anyone in the birth family had any of the following psychological disorders?

|  |  |  |
| --- | --- | --- |
| Yes | Condition | Family Member |
|   | General Developmental Delays or Cognitive Delay |   |
|   | Speech or Communication Disorder |   |
|   | Intellectual Disability |   |
|   | Attention-Deficit / Hyperactivity / Impulsivity |   |
|   | Learning Problems / Disabilities |   |
|   | Autism Spectrum / Asperger’s Disorder |   |
|   | Sleep Disorders |   |
|   | Generalized Anxiety (across many situations) |   |
|   | Social Anxiety |   |
|    | Obsessive-Compulsive DisorderPhobias |   |
|   | Depression |  |
|    | Manic-Depression / Bipolar Disorder Suicide Attempts / Suicide |   |
|   | Schizophrenia or other psychosis |  |
|   | Alcohol / Substance Abuse |   |
|   | Seizures or other neurological disorder |   |
|   | Genetic Disorder (e.g., Down Syndrome, Fragile X) |   |
|   | Other:  |

# Medical History

Name of child’s Primary Care Physician:

Physician’s Address:

Physician’s Phone:

List any other physician or health professional your child sees on a regular basis:

When was your child last seen by a physician?

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had:

List any medications your child is currently taking. Also, list previous medications and dates if taken for an extended period of time. Use back of page if needed.

# Patient Psychiatric History

Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was the presenting issues?

# Behavior Management / Discipline

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed: (circle the appropriate number)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Very | Unlikely |  |  |  | Very Likely |
| Let situation go | 1 | 2 | 3 | 4 | 5 |
| Time out | 1 | 2 | 3 | 4 | 5 |
| Send to room | 1 | 2 | 3 | 4 | 5 |
| Take away a privilege (ex., no TV) | 1 | 2 | 3 | 4 | 5 |
| Take away something material (ex., no toy) | 1 | 2 | 3 | 4 | 5 |
| Assign an additional chore | 1 | 2 | 3 | 4 | 5 |
| Ground child | 1 | 2 | 3 | 4 | 5 |
| Reason with child/problem solve/negotiate | 1 | 2 | 3 | 4 | 5 |
| Yell at child | 1 | 2 | 3 | 4 | 5 |
| Physical punishment | 1 | 2 | 3 | 4 | 5 |
| List anything else you may do: |  |  |  |  |  |
|  | 1 | 2 | 3 | 4 | 5 |
|  | 1 | 2 | 3 | 4 | 5 |

Please list the five things that you would like your child to do more of and less of in order of priority to you. For example, instead of saying, “I want my child to be more responsible,” translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Would like Child to do More Often Would like Child to do Less Often

1.
2.
3.
4.
5.

# Current Symptoms:

Please indicate if your child is experiencing any of the following:

* + School attention/concentration problems
	+ Grades dropping or consistently low
	+ Hyperactive, difficulty being still
	+ Impulsive, doesn’t think before acting
	+ Sadness or Depression
	+ Generalized Anxiety (across many situations)
	+ Specific fears/phobias (list):
	+ Social Anxiety
	+ Obsessive-Compulsive/Rigid behavior patterns
	+ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
	+ Isolated socially from peers
	+ Problems making or keeping friends
	+ Problems with eating
	+ Problems with falling asleep
	+ Problems sleeping through the night (middle of the night or early morning waking)
	+ Trouble waking up
	+ Fatigue/tiredness during the day
	+ Nightmares
	+ Noncompliant, purposely does not obey (not due to language or cognitive deficits)
	+ Oppositional, defiant behavior
	+ Problems controlling temper
	+ Tantrums/ “meltdowns”
	+ Problems with authority (breaking rules or laws)
	+ Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)
	+ Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)
	+ Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)
	+ Wetting accidents (indicate day or night wetting):
	+ Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)
	+ History of abuse (emotional, physical, sexual)
	+ Alcohol or drug use/abuse
	+ Vocal or motor tics (e.g., grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)
	+ Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)
	+ Stress from conflict between parents
	+ Stress due to family financial problems
	+ Legal situation (anyone in family)

Other behavioral problems:

# Legal History

Have you ever filed or been involved in any litigation? Please explain

Is there anything else we should know about your child that was not covered by this form?

# Insurance:

Primary Insurance: ID Number:

Name of Insured: Insured’s Date of Birth:

Insured Address: Phone:

Secondary Insurance: ID Number:

Name of Insured: Insured’s Date of Birth:

Insured Address: Phone:

# Responsible Party:

Name: Relationship: Address: Primary Phone: Alternate Phone:

**I authorize this provider to release any information, including diagnosis, treatment plans / records to third party payers and / or health practitioners. I authorize and request that my insurance company (if applicable) pay directly to the provider or medical benefits that are, otherwise, payable to me. I understand that my medical insurance may pay less than the actual bill for service or may not cover certain treatment.**

**I hereby certify that the foregoing information is accurate and complete and that in consideration of treatment and services rendered to me or my dependents by this medical office. I accept responsibility and understand that I am responsible for the charges and fees that are due at the time service is provided, unless I make arrangements in advance.**

Signature: Date:

**I, , hereby declare that I am the primary custodial parent, or legal guardian of the client, , as certifies by Birth Certificate or Family Court/Guardianship documents. If there are other parents or legal guardians involved please list them below.**

1.

 **Name relationship to client phone number**

1.

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