

# A New Tomorrow Behavioral Health Services

Tara L. Corbett MS, LPC, LPC-S Candidate, NBCC

Quanetta S. Jefferson MA, LPC-A, NBCC

Michelle Benson MA, LPC-A

Eboneika Henderson MA, LPC-A, NBCC

26 Wesmark Ct., Sumter, S.C. 29150

Phone: (803) 883-4981 Fax: (803) 883-5492

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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.

<u>Sibling Name</u>	<u>Age</u>	<u>School</u>	<u>Grade Year</u>	<u>Conduct*</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

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

\_\_\_\_ 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?

<u>Yes</u>	<u>Condition</u>	<u>Family Member</u>
___	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 Disorder	_____
___	Phobias	_____
___	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:

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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.

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### **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?

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### **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: \_\_\_\_\_