BEHAVIORAL HEALTH CHILD/ADOLESCENT

INTAKE FORM

**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

**Name of parent/guardian (if under 16 years):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street and Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City) (State) (Zip)

**Home Phone:** ( ) May we leave a message? □ Yes □ No

**Cell/Other Phone:** ( ) May we leave a message? □ Yes □ No

**E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_May we email you? □ Yes □ No

*\*Please note: Email correspondence is not considered to be a confidential medium of communication.*

**Child’s Birth Date:** \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_ **Social Security Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Age:** \_\_\_\_\_ **Child’s Current School & Grade:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Gender:** □ Male □ Female

**Medical Information:**

Is your child on Medication? Yes\_\_\_\_ No\_\_\_\_

If yes, please list medication, administration times and dosage:

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Medication** | **Dosage** | **Administration Times** | **Used for** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Insurance Information:**

|  |  |
| --- | --- |
| **Primary Insurance Co: ID# Group#** | |
| **Address:** | **City, State, Zip** |
| **Primary Insured’s Name** | **Primary Insured’s Employer:** |
| **Primary Insured’s Social Security #** | **Primary Insured’s Date of Birth:** |

**Presenting Problems and Concerns**

Describe the problem that brought you here today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check all your child’s behaviors and symptoms that you consider problematic:**

|  |  |  |
| --- | --- | --- |
| * Distractibility * Hyperactivity * Defiance * Anxiety/worry * Boredom * Sleep problems * Frequent arguments * Social discomfort * Hopelessness * Fire Setting * Stealing * Compulsive behavior * Crying spells * Sexual behavior * Swearing * Suspicion/paranoia * Fatigue * Lack of motivation * Change in appetite | * No/few friends * Aggression/fights * Panic attacks * Poor Memory/confusion * Manipulative behavior * Irritability/anger * Phobias * Thoughts of death * Work/school problems * Destroys property * Racing thoughts * Loneliness * Computer addiction * Curfew violations * Hearing voices * Recurring/disturbing memories * Visual hallucinations * Withdrawal from people | * Nightmares * Impulsivity * Eating problems * Homicidal thoughts * Fear away from home * Sadness * Depression * Toilet problems * Peer/sibling conflict * Obsessive thoughts * Self-harm behaviors * Legal problems * Running away * Wide mood swings * Low self-worth * Alcohol/drug use * Lying * Other:\_\_\_\_\_\_\_\_\_\_ |

**Are your child’s problems affecting any of the following**?

|  |  |  |  |
| --- | --- | --- | --- |
| * Handling everyday tasks * Recreational activities * Legal matters | * Self esteem * Work/School | * Relationships * Housing | * Health * Finances |

□ **Yes □ No** Has your child ever had thoughts, made statements, or attempted to *hurt him/herself?* If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Yes □ No** Has your child ever had thoughts, made statements, or attempted to *hurt*

*someone else?* If yes, please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Yes □ No** Has your child recently been physically hurt or threatened by someone else:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment:**

**Has the child ever been admitted to a hospital/treatment center for psychiatric, behavioral, or crisis situations?**   Yes  No

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your child been seen by a mental health professional before for counseling services?**

Yes  No

If yes, please write age of treatment, length of time and whom your child was seen by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Information**

If the parents are separated or divorced, what is the current child custody/visitation arrangement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Is your child currently the subject of a custody case?

□ **Yes □ No** Has your child ever been a ward of the court with DSS guardianship?

□ **Yes □ No** Does your child have any legal offenses on record or pending in the

courts?

**CONSENT FOR TREATMENT**

**My Signature Below Verifies That:**

1. I have freely elected the counseling/treatment program offered by PACE Consulting.
2. I agree to the Insurance information below:

*Your Information will be used and disclosed, as needed, to obtain payment for your mental health care services. This may include certain activities that your health insurance plan undertakes before it approves or pays for the mental health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and utilization review activities. If more than one, third party payer is responsible for payment for your health care, PACE Consulting, LLC may disclose your Information to more than one health plan and those health plans may share your Information with each other*

**Please sign below to indicate that you understand and agree to participate in counseling.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Print Minor’s Name Signature of Parent/Guardian Date

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_

(Last) (First) (Middle Initial)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client #: \_\_\_\_\_\_\_\_\_\_\_\_

(Street) (City/State) (Zip)

**This will authorize:**

Business Name/Person/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To release to:**

Name/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following information (choose one):** \_\_\_\_via fax \_\_\_\_\_\_via Mail \_\_\_\_\_\_in person

**All medical and/or clinical information:**

\_\_\_\_\_\_ Behavioral health services/psychiatric care/

psychological evaluations \_\_\_\_\_\_\_\_ Initials

\_\_\_\_\_\_ Medical Records \_\_\_\_\_\_\_\_ Initials

**AUTHORIZATION:** I certify that this request was made voluntarily and that the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by notifying PACE Consulting in writing. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider; the released information may not be protected by federal privacy regulations. This authorization will expire 12 months from the date of signature unless otherwise stated.

Signature of Client Date of Authorization

Signature of Witness Date