Behavior Health Partners PC

Form completed by:_____ **First Appointment** Date: _____

Client name: _____ Birthdate: _____

Parent/Guardian_____ Phone: _____

Relationship to client: __Biological __Step-parent __Adoptive __Grandparent __Foster __other_____

Primary Address: _____ City:_____

State:_____ Zip:_____

Method of contact: (please check all acceptable methods)

__ Telephone (land) _____ May messages be left? Yes__ No__

__ Telephone (cell) _____ Cell belongs to _____ May messages be left? Yes__ No__

__ Telephone (cell) _____ Cell belongs to _____ May messages be left? Yes__ No__

__ Texting – Number(s)_____ May messages be left? Yes__ No__

__ E-mail: _____

Please identify the **members of your household**, their **age**, and their **relationship** to the client.

Name	Age	Relationship

Parent **marital status**? Married ___ Divorced ___ Widowed ___ Single ___

Custody status: Joint Legal Sole Legal Joint Physical Sole Physical

Mother's **occupation/employer** _____

Father's **occupation/employer** _____

Insurance for client is carried by_____ (relationship) _____

Insurance carrier's birthdate: _____

Referred by _____

Secondary Address: _____ Telephone (land):_____

City: _____ Telephone (cell):_____

Zip:_____ Telephone (work):_____

Telephone(FAX):_____

Parent/Guardian Name:_____

Relationship to client: __Biological __Step-parent __Adoptive __Grandparent __Foster __other_____

Method of contact: (please check all acceptable methods)

__ Telephone (land) _____ May messages be left? Yes__ No__

__ Telephone (cell) _____ Cell belongs to _____ May messages be left? Yes__ No__

__ Telephone (cell) _____ Cell belongs to _____ May messages be left? Yes__ No__

__ Texting – Number(s)_____ May messages be left? Yes__ No__

__ E-mail: _____

Please identify the **members of this household**, their **age**, and their **relationship** to the client.

Name	Age	Relationship

Please describe the **schedule of visitation**.

_____

_____

_____

_____

What is his/her **marital status**? Married ___ Divorced ___ Widowed ___ Single ___

His/her **occupation/employer**?_____

Spouse's **occupation/employer**? _____

Please tell us about your child/yourself.

Infancy and early childhood

Please describe any **history of mental health problems** and/or **treatment** for family members:

_____

_____

Please describe any difficulty that may have been experienced during the client's **prenatal** experience:

Maternal health problems:_____

Maternal drug, alcohol, nicotine use:_____

Difficulty with delivery:_____

Length of pregnancy:_____ Birth weight:_____ Length of hospital stay:_____

Please describe the client's early **temperament** and development of his/her **routine**:

Feeding:_____

Sleep:_____

Response to change:_____

Please indicate if the client experienced any of the following **health problems** during early childhood:

Allergies	___	Head injury	___	Emergency room visits	___
Ear infections	___	Accidental injury	___	Vision/hearing problems	___
Gastrointestinal problems	___	Surgery	___	Loss of consciousness	___

Please provide details regarding these difficulties:

_____

_____

Please provide approximate ages for the following **developmental milestones**:

Sit alone	_____	Feed him/herself	_____	Bladder trained	_____
Stand alone	_____	Speak first word	_____	Bowel trained	_____
Walk alone	_____	Speak first sentence	_____	Ride a bike	_____

Please describe how much experience the client had with **peers** (e.g. daycare, siblings, neighbors) prior to starting school and provide details on her/his success with those relationships.

_____

_____

Please describe history, if any, of suspected or documented **emotional, physical or sexual abuse**:

_____

_____

_____

School years

Please describe the client's **willingness and readiness** to begin his/her formal education, such as preschool, church school, or kindergarten.

_____

_____

Current School: _____ School District:_____

Current grade: _____ Teacher:_____

General Education___ Special Education___ Homeroom___ Other_____

Teacher's phone or e-mail: _____

Please describe the client's **current school success**:

Grades _____

_____

Peer interaction _____

_____

Disciplinary actions _____

_____

Extra curricular activities _____

_____

Please describe the client's history, if any, with use of **Special Education Services**:

_____

_____

_____

Most recent IEP date: _____ Eligibility/Diagnosis: _____

Has the client ever participated in academic/psychological **assessment** at school or any other agency? If so, please provide dates and details:

_____

_____

_____

Current Concerns

Please describe your **reason(s) for seeking treatment/assessment**.

How long has the client been experiencing the difficulties for which you are seeking treatment?

What are **your expectations** for treatment?

Please provide a list of **household chores** for which the client is responsible, and indicate the degree to which she/he is consistent and independent with completion.

Please list/describe the client's **strengths**; including special skills, interests, character.

What else would you like us to know?

Please describe your child's **current medications** and the **conditions** being treated.

Prescription medications:	Condition being treated:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

"Over-the-counter" medications:	Condition being treated:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Thank you for your time and effort in providing this important information!