Behavior Health Partners PLC

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

Client's name: _____ Birthdate: _____

Client's legal sex designation: __ Female __ Male Client's pronouns: _____

Parent/Guardian

Relationship: __ Parent __ Step-parent __ Grandparent __ Guardian Other_____

Primary Address: _____ City:_____

State:_____ Zip:_____

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

Name	Age	Relationship

Parent/step-parent occupation – Employer? _____

Parent/step-parent occupation – Employer? _____

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

Custody status: __ Joint Legal __ Sole Legal __ Joint Physical __ Sole Physical

Please describe your current parenting time arrangements:

Please identify Other important people who have frequent contact with the client.

Name	Age	Relationship

Secondary Address:_____ City:_____

State:_____ Zip:_____

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

Name	Age	Relationship

Parent/step-parent occupation – Employer? _____

Parent/step-parent occupation – Employer? _____

Parent Contact Information

Mom's Cell Phone: _____ May messages be left? __ Yes __ No

Ok to send appointment reminders and messages via text? __ Yes __ No

Mom's E-mail: _____ Emergency Contact? Yes __ No

Dad's Cell Phone: _____ May messages be left? __ Yes __ No

Ok to send appointment reminders and messages via text? __ Yes __ No

Dad's E-mail: _____ Emergency Contact? __ Yes __ No

Primary Care physician: _____

Who referred you to Behavior Health Partners? _____

Insurance Information:

Who is your Primary insurance carrier? _____

Primary Insurance is carried by which parent? _____ **Date of birth:** _____

Insurance ID number: _____ **Group Number:**_____

Secondary insurance carrier? _____

Secondary is carried by which parent? _____ **Date of birth:** _____

Insurance ID number: _____ **Group Number:**_____

Family History

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

Family stressors (e.g. divorce, abuse, physical illness, financial, housing):

Please describe family cultural/spiritual characteristic you would like us to know:

Infancy and early childhood

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:_____

Infancy and early childhood cont.

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 _____

Peer Relations

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**:

Please describe previous work with mental health practitioners (e.g. counseling, behavior therapy)

Please describe any history of trauma that may have affected you or your child (Examples: major natural disaster, household fire, car accident, serious illness or hospitalization of family member, experienced or observed a physical assault, bullying, food insecurity, homelessness, saw a person who is dead or dying):

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 e-mail: _____

Teacher's telephone number: _____

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:
_____	_____
_____	_____
_____	_____

Please describe your child's **food and medication allergies:**

<u>Thank you for your time and effort in providing this important information!</u>