WIREGRASS BEHAVIORAL GROUP LLC

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Child's Name:_____ Child's Date of Birth:_____
Child's Address:_____ City, State, Zip Code_____
Date of Appointment:_____
Name of person completing form:_____
Phone #s: (H)_____(C)_____(W)_____
Relationship to child (circle): biologic parent/foster parent/step parent/adoptive parent/guardian/other
Does the child live with you?_____Caregiver marital status (circle):married/divorced/single/widowed
Second parent/guardian name:_____
Phone #s: (H)_____(C)_____(W)_____
Relationship to child (circle): biologic parent/foster parent/step parent/adoptive parent/guardian/other
Does the child live with you?_____
Who lives in the home with child (parent, siblings, guardian)?_____
Are there any living arrangements (shared custody, foster care), custody issues, parental disagreement about care, or orders of protection that we should be aware of (circle): No/Yes. Describe:_____
_____
Cell/Home Phone:_____Preferred method of contact by text or telephone call:_____
Who referred you:_____

Insurance information

Insured name:_____Insured DOB:_____
Insured carrier:_____
Insurance policy/identification number:_____
Group number:_____
Insurance provider services number:_____

What is the reason you would like your child to be seen in this clinic?_____
_____

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

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

Are your child's problems affecting any of the following (circle)? Handling everyday tasks/Self-esteem/ Work/school, Relationships, Housing, Recreational activities, Hygiene, Legal matters, Health, Finances
Has your child ever had thoughts, made statements, or attempted to hurt him/herself? Yes/No; If yes, please describe:_____
Has your child ever had thoughts, made statements, or attempted to hurt someone else? Yes/No; If yes, please describe:_____

Family and Developmental History

Family Mental Health Problems

- ☐ Hyperactivity Who?_____
- ☐ Inattention Who?_____
- ☐ Depression Who?_____
- ☐ Bipolar Disorder Who?_____
- ☐ Suicide Who?_____
- ☐ Anxiety Who?_____
- ☐ Obsessive Compulsive Disorder Who?_____
- ☐ Anger/Abusive Who?_____
- ☐ Schizophrenia Who?_____
- ☐ Eating Disorders Who?_____
- ☐ Alcohol Abuse Who?_____
- ☐ Drug Abuse Who?_____

Please check if your child has experienced any of the following types of trauma or loss:

- ☐ Emotional abuse
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Parent substance abuse
- ☐ Teen pregnancy
- ☐ Neglect
- ☐ Violence in the home
- ☐ Crime victim
- ☐ Parent illness
- ☐ Lived in foster home
- ☐ Homelessness
- ☐ Loss of loved ones
- ☐ Financial problems

Were there any medical problems during the pregnancy or birth of this child? Yes/No. If yes, please describe:_____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant? Yes/No. If yes, please describe:_____

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting etc.?) If yes, please describe:_____

Has your child ever been diagnosed with a developmental or behavioral disorder (circle)? No/Yes_____

If yes, what has he/she been diagnosed with?_____

Who made the diagnosis:_____When?_____

Previous Mental Health Treatment

		When?	Provider?	Reason?
Yes/No	Outpatient counseling			
Yes/No	Medication management			
	Past meds?			
Yes/No	Psychiatric hospitalization			
Yes/No	Drug/Alcohol treatment			

School Information

Current grade:_____ Name of school_____

This year's school grades (circle): Excellent, Good, Fair, Poor

Past school grades (circle): Excellent, Good, Fair, Poor

This year's school behavior: Excellent, Good, Fair, Poor

Past school behavior: Excellent, Good, Fair, Poor

Has your child had any of the following difficulties at school (check all that apply)? ____Suspension, ___Incomplete homework, ___Learning problems, ___Teased or picked on, ___Speech problems, ___Referrals or detentions, ___Attendance problems

Has your child ever skipped or repeated a grade? Yes/No

Has your child ever received Special Education Services? Yes/No. If yes, please describe services received and reason for services_____

Has your child ever had problems with work, school, relationships, health, or the law due to substance use? If yes, please describe_____

Substance Use History (age 12 and over or if applicable)

Does your child currently (last 6 months) any of the following substances? ___Tobacco, ___Alcohol, ___Marijuana, ___Cocaine/crack, ___Ecstasy, ___Heroin, ___Inhalants, ___Methamphetamines, ___Pain killers, ___PCP/LSD, ___Steroids, ___Tranquilizers, ___Caffeine

Has your child used any of these substances in the past? If yes, which ones? _____

Medical Information

Date of last physical exam:_____

Has your child experienced any of the following medical conditions during his/her lifetime? ___allergies, ___asthma, ___headaches, ___stomach aches, ___surgery, ___meningitis, ___diabetes, ___high fevers, ___seizures, ___hearing problems, ___vision problems, ___ear infections, ___head injury, ___serious accidents, ___sleep disorder, ___heart problems, ___pregnancy, ___sexually transmitted disease

List any CURRENT health concerns:_____

Is your child taking any prescription or over the counter medications? Yes/No. If yes, please list:_____

Allergies and/or adverse reactions to medications? Yes/No. If yes, please list:_____

_____

Has your child ever been hospitalized? If so, why?_____

Has your child ever had surgery? If so, please list?_____

Family Medical History

Please list any medical problems experienced by family members

Mother_____ Father_____

Siblings_____Cousins_____

Aunts/Uncles_____Grandparents_____

_____

Consent for Evaluation

I request that my child_____, be evaluated by a provider at Wiregrass Behavioral Health Systems. Please note: If there is joint custody, signatures are required from both parents.

Signature of parent or guardian Date

Signature of parent or guardian Date