Wiregrass Behavioral Group LLC

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Date of Appointment: ______________________________

Child's Name: ____ Child's Date of Birth: ______________________

Child's Address: ____ City, State, Zip Code: ______________________

Name of person completing form: _____________________________________ Does the child live with you? Yes No

Phone #'s: (Home) _______________ (Cell) _______________ (Work) _______________

Relationship to child: biologic parent foster parent step parent adoptive parent

guardian other ____

Caregiver marital status (circle): married divorced single widowed

Second parent/guardian name: _______________________________________ Does the child live with you? Yes No

Phone #'s: (Home) _______________ (Cell) _______________ (Work) _______________

Relationship to child: biologic parent foster parent step parent adoptive parent

guardian other ____

1. Who lives in the home with child (parent, siblings, guardian)? ____
2. 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: ____________________________

   ____
3. Preferred method of contact by: Text Telephone #: _______________
4. Who referred you: ____
5. What is the reason you would like your child to be seen in this clinic? _______________________________________

   ____

Insurance information

Insured name: ____ Insured DOB: _____________________________

Insured carrier: ____ Group #: _________________________________

Insurance policy/identification number: ____

Insurance provider services number: ____

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

6. Were there any medical problems during the pregnancy or birth of this child? Yes No;
   If yes, please describe: ____
7. Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant? Yes No;
   If yes, please describe: ____
8. Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting etc.?)
   Yes No; If yes, please describe: ____
9. Has your child ever been diagnosed with a developmental or behavioral disorder (circle)? Yes No;
   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: ____

10. This year's school grades: Excellent Good Fair Poor
11. Past school grades (circle): Excellent Good Fair Poor
12. This year's school behavior: Excellent Good Fair Poor
13. Past school behavior: Excellent Good Fair Poor
14. 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
15. Has your child ever skipped or repeated a grade? Yes No
16. Has your child ever received Special Education Services? Yes No;
    If yes, please describe services received and reason for services ____
    ____
17. Has your child ever had problems with work, school, relationships, health, or the law due to substance use?
    Yes No; If yes, please describe____

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

18. 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? Yes No;
    If yes, which ones? ____

Medical Information

19. Date of last physical exam: ____
20. 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

21. List any CURRENT health concerns: ____
22. Is your child taking any prescription or over the counter medications? Yes No
    If yes, please list:____
23. Allergies and/or adverse reactions to medications? Yes No; If yes, please list: ____________________________
    ____
24. Has your child ever been hospitalized? Yes No; If so, why? ____
25. Has your child ever had surgery? Yes No; 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

Signature below is acknowledgement that you have received the Notice of Privacy Practices & Office Policies

OUR DUTIES

- **Notice Changes -** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you and any PHI we receive in the future. Current copies of this notice will be available at registration locations. The current Notice will also be posted at our website. The effective date of the notice will be posted on the first page.
- **Cell Phone/Email Mail -** We ask you not to use your cell phone or email in contacting our healthcare providers, personally. Cell Phone and Emails sent to and from you are not secure and could be read by a third-party.
- **Complaints -** If you believe your privacy rights have been violated, then you have the right to submit a complaint to us. Any complaints shall be made in writing or by telephone to Wiregrass Behavioral Group, 256 Honeysuckle Rd. Ste 12 Dothan, AL 36305. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against or penalized in any way for filing a complaint. You may also file a written complaint with the secretary of the US Department of Health and Human Services, 200 Independence Ave. S W, Washington DC, 20201, or call toll-free 877-696-6775, by email to OCRComplaint@hhs.gov or to Region V, Office for Civil Rights, US Department of Health and Human Services, 233 North Michigan Ave, Suite 240, Chicago, IL 60601, voice phone 312-886-2359, fax 312-886-1807, or TDD 312-353-5693.

______________________________	____________________	__________
Client / Legal Guardian Printed Name	Signature	Date
______________________________	____________________	__________
Witness – Printed Name	Signature	Date

Client's Consent for Communications

Please initial below, with your selection:

______________ I ***consent*** to my cell phone, home phone or email being used for communications from Wiregrass Behavioral Group, LLC (that are non-clinical and non-urgent only)

______________ I ***do NOT consent*** to my cell phone, home phone or email being used for communications from Wiregrass Behavioral Group, LLC

Client's Understanding

☐ I have read and understood the office policies and agree to abide by the rules listed therein
☐ I agree to be an active participant in my mental health recovery
☐ I have received a copy of the Office Policies
☐ I have received a copy of the Privacy Practices

______________________________	____________________	__________
Client / Legal Guardian Printed Name	Signature	Date
______________________________	____________________	__________
Witness – Printed Name	Signature	Date