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