



# 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**



		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