



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 | ☐ Irritability/anger |
| ☐ Hyperactivity | ☐ Peer/sibling conflict |
| ☐ Inattention | ☐ Stealing |
| ☐ Impulsivity | ☐ Destroys property |
| ☐ Boredom | ☐ Running away |
| ☐ Poor memory/confusion | ☐ Curfew violations |
| ☐ Sadness/depression | ☐ Lying |
| ☐ Hopelessness | ☐ Manipulative behavior |
| ☐ Thoughts of death | ☐ No/few friends |
| ☐ Self-harm behaviors | ☐ Eating problems |
| ☐ Crying spells | ☐ Sleep problems |
| ☐ Loneliness | ☐ Nightmares |
| ☐ Low self-worth | ☐ Toileting problems |
| ☐ Fatigue | ☐ Fire setting |
| ☐ Recurring disturbing memories | ☐ Work/school problems |
| ☐ Change in appetite | ☐ Legal problems |
| ☐ Withdrawal from people | ☐ Sexual behavior |
| ☐ Anxiety/worry | ☐ Alcohol/drug use |
| ☐ Panic attacks | ☐ Lack of motivation |
| ☐ 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 | |

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
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Signature of parent or guardian	Date
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