FosterAdopt Connect Behavioral Health Patient Intake Form

Child/Adolescent Data

Name of Child: _____ _____ _____
First Middle Last

Street Address: _____

City_____ State/Zip_____

Phone Number_____ Social Security Number _____

Date of Birth_____ Place of Birth _____

Race _____ Ethnicity _____

Sexual Orientation _____ Gender Identity _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

School/Grade _____

Special Education Services_____

Who has legal custody or guardianship of child? _____

Who referred your child? _____

What was their concern? _____

_____

What is your primary concern? _____

_____

What, if any, is the school's primary concern? _____

_____

When did you first become aware of concerns? _____

Family Data

Biological Father:

Name: _____ Date of Birth _____

Address _____

Phone Number _____

Place of Employment _____ Title _____

Highest Level of Education _____

Biological Mother:

Name: _____ Date of Birth _____

Address _____

Phone Number _____

Place of Employment _____ Title _____

Highest Level of Education _____

Adoptive/Foster Father:

Name: _____ Date of Birth _____

Address _____

Phone Number _____ Email_____

Place of Employment _____ Title _____

Highest Level of Education _____ Marital Status _____

Race _____ Ethnicity _____

Adoptive/Foster Mother:

Name: _____ Date of Birth _____

Address _____

Phone Number _____ Email_____

Place of Employment _____ Title _____

Highest Level of Education _____ Marital Status _____

Race _____ Ethnicity _____

List on this page in chronological order the names of all children including the applicant, biological siblings, foster/adoptive siblings, and half siblings.

NAME	RELATIONSHIP TO YOUR CHILD	SEX	DOB	EDUCATION AND/OR OCCUPATION

_____

_____

_____

_____

_____

_____

_____

_____

List dates of moves and for what reasons.

_____

_____

_____

How long at present address? _____

What is your family gross income? (list amount on most recent tax returns) _____

What is the size of your family? (include all adults and children currently living in your home) _____

Developmental Information

Length of Pregnancy _____ Birth Weight _____

Any complications of pregnancy or exposure to drugs and/or alcohol? _____

_____

Type of delivery: _____Natural _____ Caesarian _____ Breech

Condition of child at time of birth_____

If child was adopted, from where?_____

At what age was child adopted? _____

Please give age your child: crawled_____, walked _____, talked _____, toilet trained _____

What have the significant stressors or traumas been to the family and child?

_____

_____

_____

Please check those items that pertain to your child:

____ Often fails to finish things he/she starts
____ Easily distracted
____ Has difficulty concentrating
____ Shifts excessively from one activity to another
____ Frequently disruptive in class
____ Has difficulty awaiting his/her turn (i.e. games)
____ Impulsive or acts without thinking

____ Abusive to animals
____ Physically violent towards property (i.e. vandalism, destructive)
____ Physically abusive to self (scratches self, suicidal attempts)
____ Firesetting
____ Stealing, Shoplifting, Breaking and Entering
____ Runaway
____ Lying
____ Chronic violation of parental limits
____ Drug Abuse (what kind?) _____
____ Alcohol Abuse (what kind?) _____
____ Any involvement with juvenile court
____ Unrealistic fears (Explain) _____
____ Acts too young for his/her age
____ Clings to adults or too dependent
____ Feels no one loves him/her
____ Gets teased a lot
____ Complains of loneliness
____ Demands a lot of attention
____ Easily made jealous
____ Refusal to attend school
____ Avoidance of being left along
____ Excessive need for reassurance
____ Very self-conscious or easily embarrasses
____ Often appears tense and unable to relax
____ Frequent physical complaints (i.e. headaches, stomach aches, nausea)
____ Overly concerned with future events
____ Nervous mannerisms (nail biting, thumb sucking, rocking)
____ Feelings of inadequacy
____ Panic—feelings of intense fear/discomfort with palpitations, tremors, shortness of breath, choking
____ Obsessions—unwanted ideas, images, or impulses that intrude on thinking against your wishes and efforts to resist them. (Fear of contamination, recurring doubts about danger, extreme concern with order, symmetry or exactness)
____ Can't get his/her mind off certain thoughts
____ Fears he/she may do something bad
____ Fears he/she has to be perfect

____ Strange thoughts or ideas (Explain) _____
____ Hallucinations—visual or auditory—Describe _____
____ Inappropriate expression of feelings (i.e. laughing at something sad)
____ Concern that people are out to get him/her
____ Severe mood changes (i.e. very sad to very happy)
____ Often appears sad
____ Confused or seems to be in a fog
____ Day dreams or gets lost in thought
____ Doesn't seem to have much energy
____ Social withdrawal
____ Overtired
____ Pessimistic outlook toward the future
____ Excessive tearfulness or crying
____ Recurrent thoughts about death or preoccupation with death
____ Suicidal thoughts or verbalized intentions
____ Concerns about sexual identity
____ Sexually promiscuous
____ Inappropriate sexual behavior (Explain) _____

____ Poor relationship with parents
____ Sibling rivalry
____ Negative peer associations—hangs out with others that get in trouble
____ Argues a lot, bragging, boasting
____ Mean to others
____ Has difficulty participating in organized activities (sports)
____ Avoids competitive situations

____ Sleep difficulties (i.e. sleepwalking, restless, inability to fall asleep or sleeps too much)
____ Eating difficulties (i.e. has difficulty keeping food down, overeats, does not have much of an appetite, fear of trying new foods, tremendous concern about weight)
____ Poor personal hygiene (does not keep self clean or take an interest in appearance)
____ Enuretic (urinates during the day or night on self)
____ Encopretic (soils self)
____ Deliberately harms self
____ Tics (sudden rapid, recurrent motor movements or vocalizations)
____ Behaves like the opposite sex

Psychiatric/Psychological/Medical Information

List all doctors and mental health professionals who have examined and/or treated your child. Please give name, address, and phone number for each.

Pediatrician/Family Physician_____

_____

_____

Dentist/Orthodontist _____

_____

_____

Psychiatrist/Psychologist/or Mental Health Facility_____

_____

_____

_____

Preferred Pharmacy (Name and Address) _____

_____

Date and place of last physical exam: _____

Care Coordination

Do you wish for me to coordinate with your child's other providers? Yes_____ No_____

If yes, whom?_____

_____

*If you would like me to share your child's health information with anyone other than his/her custodial parents/legal guardians, you will need to complete a Release of Information that authorizes me to do so.

Medication/Medical History

Medications your child has been on in the past for mood or behavior:

_____

_____

_____

_____

_____

Current over the counter medications, herbal remedies, and nutritional supplements your child is taking:

_____

_____

_____

What medication(s) is your child taking now (list name, dosage, and frequency)?

_____

_____

_____

_____

_____

_____

List any allergic reactions to medications:

_____

_____

_____

List any allergies that your child may have and how it is treated:

_____

_____

_____

Has your child ever had:

An EKG? (heart) Yes_____ No_____ Date_____

Please describe: _____

An MRI/PET/CT brain scan? Yes_____ No_____ Date_____

Please describe: _____

An EEG? (monitor for seizures) Yes_____ No_____ Date_____

Please describe: _____

If your child has ever been **hospitalized** please explain when and for what reason.

Name of Hospital	**Date**	**Diagnosis/Reason**

_____

_____

_____

_____

_____

_____

Has the child ever been exposed to abuse? Please state whether it is/was physical, emotional, or sexual and whether he/she was subjected to the abuse or exposed to it.

_____

_____

_____

_____

_____

_____

Please check if any of the following pertain to your child:

____ Heart Disease ____Nausea or vomiting ____ Concussions

____ Lung Disease ____Drug or alcohol abuse ____ Nervous disorders

____ Liver Disease ____Diarrhea (frequently) ____ Neurological testing

____ Jaundice ____Diabetes ____ High fevers

____ Seizures ____Tonsillectomy ____ Injuries or broken bones

____ Fainting ____Orthodontia ____ Accident prone

____ Asthma ____Skin Disease ____ Activity limitations

____ Dietary problems ____Irregular Sleep Patterns ____ Hearing problems

____ Visual problems ____Speech problems ____ Urinary problems

____ Bowel or elimination problems ____Other (describe) _____

Gynecology

____ Pregnancy

____ Abortion (if so, when) _____

____ Miscarriage (if so, when) _____

____ Menstrual problems

____ Birth Control (if so, what type) _____

Behavioral Health Family History

Please check which, if any, of the following conditions/problems apply to your child's blood relatives. If other significant medical/behavioral health problems are present among blood relatives, please list those in the space provided below

	Child's Mother	Child's Father	Child's Brother(s)	Child's Sister(s)	Child's Grandparent	Other
Childhood oppositional/defiant disorder						
Problems with aggression						
Attentional problem						
Learning disability						
Failed high school						
Intellectual Disability						
Psychosis/schizophrenia						

Depression						
Anxiety or adjustment disorder						
Panic disorder						
Tic disorder or Tourette's						
Alcohol Abuse						
Substance Abuse						
Antisocial behavior (assault/theft)						
Arrests/incarceration						
Physical abuse (victim)						
Physical abuse (perpetrator)						
Sexual abuse (victim)						
Sexual abuse (perpetrator)						
Other mental disorder (list below)						

Name of person completing this form _____

Relationship to applicant _____

I do certify that all the foregoing information is true and complete

Name_____ Date_____