Granville HEALTH SYSTEM Please Fill Out Completely – Blanks will **Delay** Appointment, thank you!

Behavioral Health Services
Child/Adolescent Intake Questionnaire

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The following questionnaire is to be completed by the parent or guardian. This form has been designed to provide necessary information to our staff before our initial conference in order to make the most productive and efficient use of our actual time together. As you complete this form, please feel free to add any additional information which you think may be helpful to us in understanding your child. All information provided by you is strictly confidential and will not be released to anyone without your written request.

GENERAL INFORMATION		
Today's Date:	Person Completing/Relationship:	
Child's Name/Nickname:	**Date of Birth**:	Age:
Home Street Address:		
City State Zip:		
GENDER AT BIRTH:	**Social Security#:**	
Home Phone#	**Religion:**	
Birth Mother's Name/Date of Birth:	Birth Father's Name/Date of Birth:	
Mother work phone# Cell#	Father work phone# Cell#	
E-Mail:	**E-Mail:**	
Who is child's legal guardian(s)? **If child's guardian is someone other than biological parents, please provide copy of guardianship papers.		

Insurance (Mental Health):

Primary Ins. _____ Secondary Ins. _____

Policy Holder _____ Policy Holder _____

Policy # _____ Policy # _____

Policy Holder's Date of Birth _____ Policy Holder's Date of Birth _____

Customer Service Phone # _____ Phone # _____

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Please Complete and be prepared to discuss the following at the evaluation appointment:

Reason for Mental Health Treatment

Please describe the problems patient is having **NOW**:

_____

Previous mental health treatment: ___ **yes** ___ no
If yes please list:

Previous use of psychiatric medications: ___ **yes** ___ no
If yes please list: _____

Child's Substance Use: ___ past ___ current ___ never

Psychiatric/ Substance Use History ___ **yes** ___ no
Alcohol: ___ yes ___ no If yes, # of drinks per day ___per week ___
Illegal Drugs: ___ yes ___ no
Prescription Drugs: ___ yes ___ no
Overuse history? ___ yes ___ no
Treatment? ___ yes ___ no
If yes, where/when_____

Current Medical Problems: ___ yes ___ no
*List on Intake Questionnaire on page 12 and **bring all** of your **prescription bottles and Over-the-Counter** medications to your appointment

Medical History: ___ yes ___ no
*List conditions and dates on Intake Questionnaire page 11
History of significant head injury? ___ yes ___ no
History of seizures (epilepsy)? ___ yes ___ no

Allergies to Medications: ___ yes ___ no
If yes, please list medication and reaction:
_____

Child's Habits:

Cigarettes:	___ yes	___ no	___ in the past
E-Cigarette:	___ yes	___ no	___ in the past
Chewing Tobacco:	___ yes	___ no	___ in the past
Caffeine:	___ yes	___ no	___ in the past
Eating Habits:	___ poor	___ good	___ excellent
Exercise Habits:	___ poor	___ good	___ excellent

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Where was Child/Adolescent born? _____

Where raised? _____

History of Traumatic Events?

_____

_____

Sexual Abuse history: ___ yes ___ no

Physical Abuse History: ___ yes ___ no

Emotional Support System: ____ poor ____ good _____ excellent

Please list the Name/Age/Relationship of those currently living with child/adolescent (including pets):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DID A PROVIDER/CLINIC REFER YOUR CHILD? _____

If so, please provide name and phone? _____

REASON FOR REFERRAL / CURRENT SYMPTOMS
Please describe the problems your child/adolescent is now having and the type of services you are seeking.

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Please check any of the following difficulties your child/adolescent is experiencing:			
	School attention/concentration problems		Hyperactive, difficulty being still
	Grades dropping or consistently low		Sadness or Depression
	Impulsive, doesn't think before acting		Obsessive-Compulsive / Rigid behavior patterns
	Generalized Anxiety (across many situations)		Problems making or keeping friends
	Isolated socially from peers		Social Anxiety
	Problems with eating		Specific fears/phobias (list):
	Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)		
	Problems falling asleep		Trouble waking up
	Problems sleeping through the night (middle of the night or early morning waking)		Sleeping Walking
	Fatigue/tiredness during the day		Nightmares or Night Terrors
	Disobedient, purposely does not obey (not due to language or cognitive deficits)		Oppositional, defiant behavior
	Problems controlling temper		Tantrums / "Meltdowns"
	Problems with authority (breaking rules or laws)		Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)
	Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)		Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)
	Wetting accidents (indicate day or night wetting):		Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)
	History of abuse (emotional, physical, sexual)		Alcohol or drug use/abuse
	Vocal or motor tics (e.g., grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)		Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)
	Stress from conflict between parents/guardians		Stress due to family financial problems
	Legal situation (anyone in family)		Other behavior problems:

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PARENTS / GUARDIANS AND FAMILY INFORMATION:

BIOLOGICAL MOTHER
Name:
Age at child's birth: Current Age:

Occupation: Education Level Completed:
Physical Health: _____Excellent _____Good _____Fair _____Poor
Mental/Emotional Health: _____Excellent _____Good _____Fair _____Poor
Substance Use:
Alcohol Use: _____Yes _____No #Drinks per day _____ #Drinks per week ____
Illicit Drugs: _____Yes _____No Substance_____
Prescription Drug Misuse _____Yes _____No
Overuse History? ____Yes _____No
Treatment? _____Yes _____No Where/When? _____
Caffeine: _____Yes _____No
Cigarettes: _____Yes _____No _____In the past E-cigarettes: ____Yes _____No _____In the past
Chewing Tobacco: ____Yes ____No

BIOLOGICAL FATHER
Name:
Age at child's birth: Current Age:

Occupation: Education Level Completed:
Physical Health: _____Excellent _____Good _____Fair _____Poor
Mental/Emotional Health: _____Excellent _____Good _____Fair _____Poor
Substance Use:
Alcohol Use: _____Yes _____No #Drinks per day _____ #Drinks per week ____
Illicit Drugs: _____Yes _____No Substance_____
Prescription Drug Misuse _____Yes _____No
Overuse History? ____Yes _____No
Treatment? _____Yes _____No Where/When? _____
Caffeine: _____Yes _____No
Cigarettes: _____Yes _____No _____In the past E-cigarettes: ____Yes _____No _____In the past
Chewing Tobacco: ____Yes ____No

Biological Parents Marital Status (circle one): Married Divorced Cohabitants

If married, how long have you been married?

If divorced, how long have you been divorced?

If biological parents are divorced, who has physical custody?
Is it full or joint?

Who has legal custody?
Is it full or joint?

****Please provide a copy of the custody agreement.**

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Has either parent been married before or since?

Mother: _____Yes _____ No If yes dates_____	Father: _____Yes _____ No If yes dates_____
If yes, names, and ages of children from these marriages:	
Children and ages:	Children and ages:
Is there a birth parent living outside the home: (circle one) MOTHER FATHER	Where does this parent live?
If birth parent(s) do/does not live in the child's home, how much contact does the child have with the parent(s) not having custody, with stepsiblings, etc.?	
How would you rate the quality of your present marriage? Each parent circle choice	
Mother: Great - Very Good- Good- Fair- Poor- Very Poor	**Father:** Great - Very Good- Good- Fair- Poor- Very Poor
Does either parents job requires him/her to be away from home long hours or extended periods? If yes, explain:	
Who supervises the child's care when not in school?	
Siblings: List IN ORDER OF AGE siblings and ½ siblings of child/adolescent for whom you are seeking services. Sibling Name Age School Grade Average Conduct*	
*(Please indicate good, fair, or poor conduct)	

In general, how would you say the child for whom you are seeking services gets along with these siblings?

_____Great _____ Very Good _____ Good _____Fair _____ Poor ____ Very Poor

Describe relationship between child/adolescent and sibling(s):

_____

_____ _____

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Others: List any other people who currently, or in the child's lifetime, have lived in your home (other family members, caregivers, nannies, etc.).

NAME	AGE	RELATIONSHIP TO CHILD/ADOLESCENT	#YEARS LIVING IN HOME
1.			
2.			
3.			
4.			

Indicate time each person was living in home (match # of person with # below):

FROM	TO
1.	
2.	
3.	
4.	

Are there other relatives who have OR had a significant impact on how this child is raised? _____yes _____no

If yes, please list:

FAMILY STRESS LEVEL Please rate the overall level of FAMILY stress:

_____Very Low ____Low _____Average _____High _____Very High

What is the greatest source of stress for the family at this time? _____

_____

Please rate the overall level of stress in the mother's life:

_____Very Low _____Low _____Average _____High _____Very High

What are the greatest sources of stress in the mother's life? _____

_____

Please rate the overall level of stress in the father's life:

_____Very Low _____Low _____Average _____High _____Very High

What are the greatest sources of stress in the father's life? _____

Each parent please rate your overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY)

Mother: _____ Father: _____

FAMILY HISTORY

Has anyone in the **BIRTH** family had any of the following psychological disorders?
___Yes or ___No
If yes, please check all that apply and list who:

Condition	Yes	Family Member(s)
General Developmental Delays or Cognitive Delay		
Speech or Communication Disorder		
Intellectual Disability (mental retardation)		
Attention-Deficit / Hyperactivity / Impulsivity		
Learning Problems / Disabilities		
Autism Spectrum / Asperger's Disorder		
Sleep disorders		
Generalized Anxiety (across many situations)		
Social Anxiety		
Obsessive-Compulsive Disorder		
Phobias		
Depression		
Manic-Depression / Bipolar Disorder		
Suicide attempts / Suicide		
Schizophrenia or other psychosis		
Alcohol / Substance Abuse		
Seizures or other neurological disorder		
Genetic Disorder (e.g., Down Syndrome, Fragile X)		
Other:		

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Is there a history in the immediate or extended **BIRTH** family of any medical difficulties, illnesses or surgeries?
_____Yes or _____No If yes, please list:

Medical Illness/Surgery	Family Member(s)

CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

Any difficulties during the pregnancy or delivery of this child? Please list any medications, periods of bed rest, etc.
Child was born: _____premature _____at full term _____late
Birth Weight lbs., oz:
Difficulties following delivery?
Nursery (check all that apply): _____Well-baby _____Transitional ____Intensive Care _____Other
Describe your child's temperament as an infant (e.g., easy-going, irritable, passive, difficult to soothe, etc.)
Any medical problems diagnosed in infancy?

As an **infant**, did this child seem:

_____less active than average _____average _____overly active

As a **toddler**, did this child seem:

_____ less active than average _____ average _____overly active

As a **preschooler**, did this child seem:

_____ less active than average _____ average _____ overly active

As the child entered school, did this child seem:

_____less active than average _____ average _____ overly active

At what age did your child accomplish these developmental tasks? If your child has not met one or more milestones, leave those items blank or write "not yet."

Developmental Tasks	**Write: Early On-Time Late OR Approximate age (if known)**
Speech and Language	
Coo/babble	
Respond to name	
Say first word	
Use gestures (wave, point)	
Put words together	
Speak in sentences	
Follow simple directions	
Follow multistep directions	
Motor Skills	
Roll over	
Sit alone	
Stand alone	
Walk alone	
Hold pencil correctly to mark	
Write legibly	
Self-Help/Independence	
Feed self	
Toilet train (bladder)	
Toilet train (bowel)	
Dress self	
Bathe self	
Social/Emotional	
Smile at others	
Laugh aloud	
Show affection	
Engage in pretend play	
First friendship	
Control feelings when upset	
Understand others' feelings	
Show responsibility	

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PATIENT'S MEDICAL HISTORY

Name of Child's Primary Care Physician:
Physician's Address:
Physician's Phone:
List any **other physicians or health professionals** your child/adolescent sees for services on a regular basis.
When was your child/adolescent **last seen** by primary care provider?
Rate your child's overall health _____Excellent _____Good _____Fair _____Poor
Child's current height: _____ft, _____in. Weight: lbs.
Does your child have any vision problems?
Date of last **vision test** and who performed primary care physician, optometrist, or school system?
Does your child have any hearing problems?
Date of last **hearing test** and who performed primary care physician, audiologist, or school system?
Is your child: _____right-handed _____left-handed _____does not favor one hand
List any operations, serious illnesses, injuries (**especially head**), hospitalizations, allergies, ear infections, or other medical conditions your **child/adolescent** has had in space below**:**

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List any **medications** your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time. Use back of page if needed.
Preferred PHARMACY: **Name** **Address** **Phone#:**
ALLERGIES: _____ **Reaction:**
Describe your child's regular diet (i.e., favorite and least favorite foods).
Do you have any concerns about your child's eating habits (e.g., aversion to certain tastes, textures, overly restricted eating, overeating, unhealthy eating, etc.…)?
What is your child's typical bedtime and wake time each day? Any concern about your child's sleeping habits?
Has your child had any previous psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings? _____

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EDUCATIONAL AND SOCIAL HISTORY

Current School: _____ **Grade**: _____

Telephone #: _____ Fax number: _____

Teacher Names:_____

List in chronological order **all** schools your child has attended:

Name of School	**Grade Placement**	**Average Conduct***
1.		*(Please indicate good, fair, or poor conduct)
Dates Attended From	To:	
2.		
Dates Attended From	To:	
3.		
Dates Attended From	To:	
4.		
Dates Attended From	To:	
What concerns does your child's teacher have about him/her?		
What is your child's favorite subject?		
What is your child's least favorite subject?		
Has your child ever repeated a grade? If so, which?		
Has your child ever skipped a grade? If so, which?		
Has your child ever had tutoring? Which subjects? When and with whom?		
Has this child ever been in a Special Education Program? If so, during what years? How much of the school day? What type of program? (LD, Gifted, EBD, ASD, etc.):		

Child's attitude toward school:
How does your child interact with peers and adults in social situations?
Do you have concerns about your child's social skills or development?

List your child's extracurricular activities, including sports, clubs, hobbies, lessons, etc.:

Sports (list):	Music (list):
Clubs/Groups (list):	Dance (list):
Other:	Other:

Describe your child's:

Strengths	Positive qualities	Any special abilities or skills

BEHAVIOR MANAGEMENT / DISCIPLINE

Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed:

(C**ircle** the appropriate number where **1=very unlikely and 5=very likely)**

Let situation go	1 2 3 4 5
Time out	1 2 3 4 5
Take away a privilege (ex., no TV)	1 2 3 4 5
Send to room	1 2 3 4 5
Take away something material (ex., no dessert)	1 2 3 4 5
Ground child	1 2 3 4 5
Assign an additional chore	1 2 3 4 5
Reason with child / Problem-Solve / Negotiate	1 2 3 4 5
Physical punishment	1 2 3 4 5
Yell at child	1 2 3 4 5
List anything else you may do:	

***Go back and rate the **THREE MOST effective** strategies. ***

Place a 1 by the most effective, a 2 by the next most effective, and a 3 by the third most effective. Then, please **circle** the strategy that is **LEAST** effective.

Please rate what percentage of discipline is handled by each of the following:

Father: _____% Mother: _____% Other: _____% (Please specify):_____

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Would like Child to do More Often	Would like Child to do Less Often
1. _____	_____
2. _____	_____
3. _____	__ _____
4. _____	_____
5. _____	_____

LEGAL HISTORY

Has patient ever been in trouble with law enforcement or DSS Involvement? ___ Yes or ___ No

If yes, please explain: _____

_____

Has either **PARENT/GUARDIAN** ever filed or been involved in any litigation? Law Enforcement?

___ Yes OR ___ No

If yes, please explain: _____

_____

_____

Is there anything else we should know about your child that was not covered by this form?

_____

_____

_____

_____

_____

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NEW CLIENT INFORMATION

Welcome to the Granville Health System's Behavioral Health Services (BHS). This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask our administrative staff about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your doctor is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes.

The only exception to these conditions may occur in situations such as child abuse, danger to life or workers' compensation where by law other action is permitted. Please discuss this with your doctor or administrative staff.

Office Hours and Appointment Information:

Our office hours are 8am-5pm the psychiatrist appointment hours are 8:30am to 4:30pm daily, and the office is closed for lunch from 12:00pm- 1:00pm. Individual appointments are set for specific physician. Both have multiple appointments each day and they require a safe, quiet, and private environment for each patient they see; therefore:

- It is unacceptable for **UNATTENDED** children/adolescents under the age of 15 to be in the waiting room without an adult.
- Please make plans for the childcare of siblings or bring a family member or friend with you to monitor your children/adolescents during the session.
- The psychiatrist WILL need to meet with you about your children/adolescents during or after each session; therefore, arrangements for childcare should be made BEFORE the appointment.
- BHS staff is **NOT** responsible for monitoring your children.

All patients need a quiet and peaceful environment for positive and full engagement in the therapeutic process, so please respect and be considerate of others while at BHS.

Appointments

To schedule, reschedule, or cancel an appointment, please call the main business number at 919-690-3217 and select option 1.

If you need to cancel or reschedule an appointment, a minimum of a **24-hour** notice is required.

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FEES:

BHS is owned by Granville Health System. Services are billed as Outpatient Facility. Many Commercial Insurance Plans have a deductible that must be paid by guarantor (patient or representative) before insurance will pay provider for claims. This means, if you have, for example a $1,000 deductible, but have only paid $200 towards it during the calendar year, you will pay the difference which is your outstanding deductible amount of $800 as fees are incurred, if we are in network. If we are out of your insurance plan network, please check with your insurance plan to determine benefits. *Patients are expected to be aware of their individual insurance benefit plan, know if they have met their annual deductible, and their co-insurance amounts.

Additionally, it is the patient's responsibility to notify our staff in the event your insurance carrier changes or coverage has lapsed. Self-pay payment/co-insurance/copay for services is due and payable at the time they are rendered. All clients are expected to take care of their fees as services are rendered.

Self-pay fees for patient without insurance:

$220 **for initial psychiatric evaluation by psychiatrist**

$200 for psychiatric 60-minute follow-up in office or telehealth
$ 175 for psychiatrist 40-minute follow-up in office or telehealth
$ 150 for psychiatrist 20-minute follow-up in office or telehealth
$ 100 for psychiatrist 15-minute medication management in office or telehealth

(Rates Subject to Change)

No Show Policy

- Appointment times are reserved specifically for you, and the schedule is set accordingly.
- A **"No Show"** is considered such when someone misses an appointment without cancelling this appointment within 24-hour notice.
- **3 missed appointments in a 12-month period** without notification may result in termination of services for patients, as missed appointments suggest non-compliance with treatment.
- Patients who have been discharged can receive a 30-day supply of their current medications and contact information of other providers in the area.
- We will notify your referral source of the missed appointments.
- If **2** Initial Psychiatric Evaluations are **missed,** patient will **not be able to reschedule**

Prescriptions and Prescription Refills

It is the responsibility of the patient or parent/guardian to call for medication **refills at least 5 days** before medication runs out. **You must contact your pharmacy for all prescription refills.** Your pharmacy will in turn contact our office for approval and/or authorization. This allows needed time to review your chart and contact the pharmacy. Some medications require you to call this office for new prescriptions, **such as stimulants like Adderall, Ritalin, Concerta, Metadate, etc.**…

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ALL patients must be seen by the physician at minimum once every 90 days for continued medication management.

*****A complete copy of BHS policies will be given at first appointment.**

I have read and understand these policies.

I acknowledge **responsibility for all fees** incurred**.**

Patient's Name:_____ **Date:**_____

Signature of Patient/Patient Representative

Witness