

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

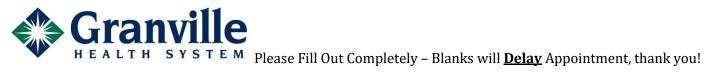
Behavioral Health Services Child/Adolescent Intake Questionnaire

Stephan F. Baum, MD, DLFAF April E. Welborn, MD, PhD 102 Professional Park Dr., Suite A PO Box 947, Oxford, NC 27565

Phone: 919-690-3217, Fax: 919-690-3218

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.

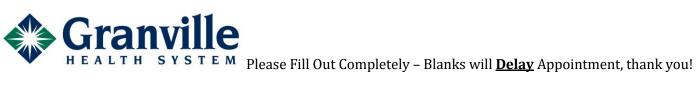
GENERAL INFORMATION				
Today's Date:	Person Completing/Relationship:			
Child's Name/Nickname:	Date of Birth:		Age:	
Home Street Address:				
City State Zip:				
GENDER AT BIRTH:		Social Security#:		
Home Phone#		Religion:		
Birth Mother's Name/Date of Birth:		Birth Father's Name/Date of E	Birth:	
Mother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



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

Reason for Mental Health Treatment

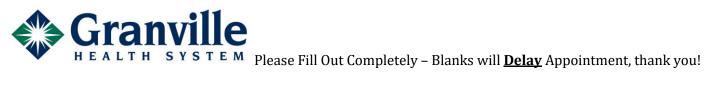
Please describe the problems patient is having <u>NOW</u> :
Previous mental health treatment: yes no If yes please list:
Previous use of psychiatric medications: yes no If yes please list:
Child's Substance Use: past current never
Psychiatric/ Substance Use Historyyes no Alcohol:yes no
Current Medical Problems: yes no *List on Intake Questionnaire on page 12 and <u>bring all</u> of your <u>prescription bottles and Over-the-Counte</u> 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



Where was Child/Adolesce	ent born?			
Where raised?				
History of Traumatic Events?				
Sexual Abuse history:	yes			
Physical Abuse History:	yes	no		
Emotional Support System:	poor	good	excellent	
Please list the Name/Age/Relatio	nship of those cu	rrently living wi	th child/adolescent (i	ncluding pets):
DID A PROVIDER/CLINIC REFE	R YOUR CHILD?			
If so, please provide name and	phone?			
REASON FOR REFERRAL / CUR Please describe the problems you seeking.		s now having and	the type of services you	<u>ı are</u>



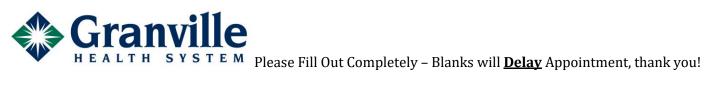
School attention/concentration problems	Hyperactive, difficulty being still	
Grades dropping or consistently low	Sadness or Depression	
Impulsive, doesn't think before acting	Obsessive-Compulsive / Rigid behavi	
	patterns	
Generalized Anxiety (across many situations)	Problems making or keeping friends	
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 towar 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 problem	
Legal situation (anyone in family)	Other behavior problems:	



PARENTS / GUARDIANS AND FAMILY INFORMATION:

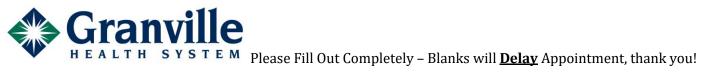
BIOLOGICAL MOTHER
Name:
Age at child's birth: Current Age:
Occupation: Education Level Completed: Physical Health:ExcellentGoodFairPoor Mental/Emotional Health:ExcellentGoodFairPoor Substance Use: Alcohol Use:YesNo #Drinks per day #Drinks per week Illicit Drugs:YesNo Substance Prescription Drug MisuseYesNo Overuse History?YesNo Treatment?YesNo Where/When? Caffeine:YesNo In the past E-cigarettes:YesNoIn the past Chewing Tobacco:YesNo
BIOLOGICAL FATHER Name: Age at child's birth: Current Age:
Occupation: Education Level Completed: Physical Health:ExcellentGoodFairPoor Mental/Emotional Health:ExcellentGoodFairPoor Substance Use: Alcohol Use:YesNo #Drinks per day#Drinks per week Illicit Drugs:YesNo Substance Prescription Drug MisuseYesNo Overuse History?YesNo Treatment?YesNo Where/When? Caffeine:YesNo In the past E-cigarettes:YesNoIn the past Chewing Tobacco:YesNo
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.



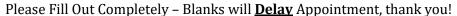
Has either parent been married before or since?

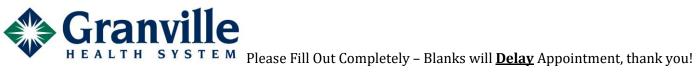
Mother:YesNo	Father:YesNo
If yes dates	If yes dates
If yes, names, and ages of children from these mar	ū
Children and ages:	Children and ages:
Is there a birth parent living outside the home: (circle one) MOTHER FATHER	Where does this parent live?
	ome, how much contact does the child have with the
parent(s) not having custody, with stepsiblings, et	rc.?
How would you rate the quality of your present m	arriage?
Each parent circle choice	arriage:
Mother:	Father:
Great - Very Good- Good- Fair- Poor- Very Poor	Great - Very Good- Good- Fair- Poor- Very Poor
Does either parents job requires him/her to be aw	vay from home long hours or extended periods?
If yes, explain:	
747	10
Who supervises the child's care when not in school	01?
Siblings:	
•	hild/adolescent for whom you are seeking services.
Sibling Name Age School	Grade Average Conduct*
	*(Please indicate good, fair, or poor conduct)
	(Flease maleate good, fair, or poor conduct)
	(Freuse marcate good, rain, or poor conduct)
In general, how would you say the child for whom	<u> </u>
In general, how would you say the child for whom	<u> </u>
	you are seeking services gets along with these siblings?
GreatVery Good	you are seeking services gets along with these siblings? _GoodFair Poor Very Poo
	you are seeking services gets along with these siblings? _GoodFairPoorVery Poor
GreatVery Good	you are seeking services gets along with these siblings? _GoodFairPoorVery Poor



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

NAM	Е	AGE	RELATIONSHIP TO CHILD/ADOLESCENT	#YEARS LIVING IN HOME
1.			- ,	
2.				
3. 4.				
Indicate time e	ach person was livin	ıg in home (m	atch # of person with # bo	elow):
	FROM			TO
1.				
2.				
3. 4.				
	relatives who have	OR had a sign	nificant impact on how thi	s child is raised?yes
	alaaaa liat.			
J / I				
FAMILY STRES	SS LEVEL Plea	se rate the ov	rerall level of FAMILY stre	ss:
Very Low	Lovy	Avoro	ugo Uigh	Vory High
very Low	LOW	Avera	ngeHigh	very riigii
What is the gre	atest source of stres	s for the fami	ly at this time?	
S				
Please rate the	overall level of stres	ss in the moth	er's life:	
Vorm	Lovy	Arron	aga High	Voru High
very Low	LOW	Aver	ageHigh	very nigh
What are the gi	reatest sources of st	ress in the mo	other's life?	
<u> </u>				
Please rate the	overall level of stres	ss in the fathe	r's life:	
Very Low	Low	Aver	ageHigh	Very High
What are the gi	reatest sources of st	ress in the fat	her's life?	
Each parent ple	ease rate your overa	ll level of hap	piness on a scale of 1-5 (1	= UNHAPPY, 5 = HAPPY)
Mother:	_		Father:	

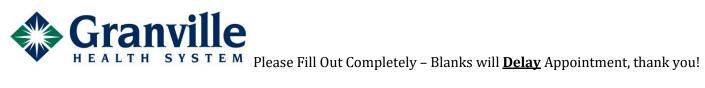




FAMILY HISTORY

Yes orNo		
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:		

Has anyone in the **BIRTH** family had any of the following psychological disorders?

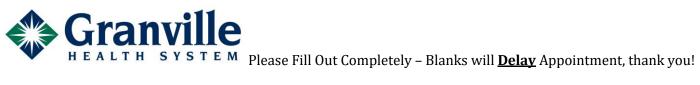


Is there a history in the immediate or extended B Yes orNo If yes, please list:	EIRTH family of any medical difficulties, illnesses or surgeries
Medical Illness/Surgery	Family Member(s)
CHILD/ADOLESCENT DEVELOPMENT	TAL HISTORY
Any difficulties during the pregnancy or delivery Please list any medications, periods of bed rest, 6	
Child was born:premature	_at full termlate
Birth Weight lbs., oz:	
Difficulties following delivery?	
Nursery (check all that apply):Well-baby Describe your child's temperament as an infant (soothe, etc.)	TransitionalIntensive CareOther e.g., easy-going, irritable, passive, difficult to
Any medical problems diagnosed in infancy?	
As an infant , did this child seem:	
less active than averageaverage	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	

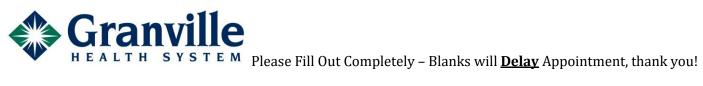


PATIENT'S MEDICAL HISTORY

Name of Child's Primary Care Physician:			
Physician's Address:			
Physician's Phone:			
List any other physicians or health professiona regular basis.	ls your child/adolescent sees for services on a		
When was your child/adolescent last seen by prin	mary care provider?		
Rate your child's overall healthExcellentGoodFairPoor			
<u> </u>	Veight: 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 prim	nary care physician, audiologist, or school system?		
Is your child:right-handedleft-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:			



List any <u>medications</u> your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements <u>(include dosages)</u> . 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?



EDUCATIONAL AND SOCIAL HISTORY

Current School:		Grade:	
Telephone #:		Fax number:	
Teacher Names:			
List in chronological o	order <u>all</u> schoo	ls your child has attended:	
Name of School		Grade Placement	Average Conduct*
1.			*(Please indicate good, fair, or poor conduct)
Dates Attended	From	То:	
2.			
Dates Attended	From	To:	
3.			
Dates Attended	From	To:	
4.			
Dates Attended	From	То:	1
What concerns does y	our child's tea	cher have about him/her?	
What is your child's fa	vorite subject	?	
What is your child's le	east favorite su	bject?	
Has your child ever re	peated a grade	e? If so, which?	
Has your child ever sk	sipped a grade?	? If so, which?	
Has your child ever ha Which subjects? When and with whom	· ·		
Has this child ever bed If so, during what yea	en in a Special	Education Program?	
How much of the scho	ool day?		
What type of program	ı? (LD, Gifted, E	EBD, ASD, etc.):	



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

Child's attitude toward school:			
How does your child interact with peers and adult	s 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):		

Dance (list):

Other:

Describe your child's:

Clubs/Groups (list):

Other:

Strengths	Positive qualities	Any special abilities or skills

BEHAVIOR MANAGEMENT / DISCIPLINE

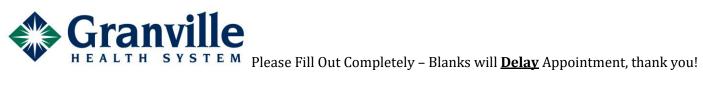
Parents may use a wide range of discipline strategies with their children. Listed below are several examples. Please rate how likely you are to use each of the strategies listed:

(Circle 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 perc	entage of discipline is ha	indled by each of the following:	
Father:%	Mother:%	Other:% (Please specify):	
you. For example, inst	tead of saying, "I want m	our child to do more of and less of in order of priority of child to be more responsible," translate that into act or brothers and sisters, etc.	
Would like Child to do	o More Often	Would like Child to do Less Often	
1			
2			
3			
4			
5			
		ment or DSS Involvement? Yes or No	
Has either PARENT/GU	JARDIAN ever filed or been	n involved in any litigation? Law Enforcement?	
Yes OR No			
If yes, please explain:			
Is there anything else w	re should know about your	child that was not covered by this form?	



HEALTH SYSTEM Please Fill Out Completely – Blanks will <u>Delay</u> Appointment, thank you!

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.



HEALTH SYSTEM Please Fill Out Completely – Blanks will <u>Delay</u> Appointment, thank you!

FEES:

BHS is owned by Granville Health System. Services are billed as Outpatient Facility. Many

Commercial Insurance Plans have a deductible that <u>must be paid by guarantor (patient or representative)</u> 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
<u>\$200</u>	for psychiatric 60-minute follow-up in office or telehealth
<u>\$ 175</u>	for psychiatrist 40-minute follow-up in office or telehealth
<u>\$ 150</u>	for psychiatrist 20-minute follow-up in office or telehealth
<u>\$ 100</u>	for psychiatrist 15-minute medication management in office or telehealth
	(Rates Subject to Change)

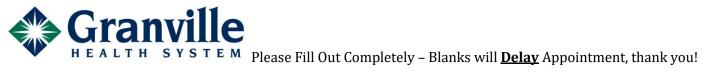
(Rates Subject to Change)

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 <u>missed</u>, patient will <u>not be able to reschedule</u>

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....



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 <u>:</u>	
Signature of Patient/Patient Representative		
Witness		