BEHAVIORAL HEALTH SOLUTIONS -MENTAL HEALTH EVALUATIONS

Child/Adolescent Registration & Background Information

Evaluation Date:_____Date of Birth:_____

Name of Person Being Evaluated:_____

Name of Person Completing the Evaluation_____

Address:_____

City/State/Zip:_____

Home Phone:_____ Okay to leave message? ☐ Yes ☐ No

Work Phone:_____ Okay to leave message? ☐ Yes ☐ No

Cell Phone:_____ Okay to leave message? ☐ Yes ☐ No

Referral Sources

- ☐ Parent
- ☐ Physician _____
- ☐ Mental Health Professional _____
- ☐ Other _____

Primary Care Physician: _____

Would you like a copy of the evaluation sent to your child's primary care physician? ☐ Yes ☐ No

Name of Insurance Company:_____

My insurance company covers _____% of mental health services and I pay _____% (co-payment).

Have you met your deductible for this year? ☐ Yes ☐ No *(Please provide your insurance card)

Payment:

The cost of the evaluation is $375.00 and is due at the time of the evaluation (by check, cash or credit card). This includes the 2-hour assessment, follow-up clinical interview, recommendations & treatment plan, treatment referrals (as needed), and a written report sent to any other healthcare provider you designate. Please either be prepared to make full payment the day of the assessment or the appropriate co-pay if you have insurance coverage for mental health services and have met your deductible. Thank you.

Child/Adolescent Background Information

Person completing this Registration Form: ☐ Mother ☐ Father ☐ Self ☐ Other_____

Name of person being evaluated:_____Age_____

Sex: ☐ Male ☐ Female

Ethnic Group:

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Other _____

Are the **Parents** of this Child: (Check One):

- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Deceased (both, one)

What was the last grade your child completed? _____

Where is the child being raised (City, State)? _____By Whom?_____

How many brothers and sisters are in the child's family of origin? _____ What number is he/she? _____

How would you describe the child's relationship with his/her parents? _____

_____

How would you describe his/her relationship with siblings?_____

_____

What is the dominant mood or moods your child is experiencing with which he/she is having difficulty?

- ☐ Anxiety
- ☐ Irritability
- ☐ Euphoria
- ☐ Depression
- ☐ Lack of Focus
- ☐ Other_____

In which areas of your child's life have these moods created difficulty for him or her?

Areas	Parent	Child
Normal Routine	☐ Yes ☐ No	☐ Yes ☐ No
Academic/School Functioning	☐ Yes ☐ No	☐ Yes ☐ No
Occupational Functioning	☐ Yes ☐ No	☐ Yes ☐ No
Home Life	☐ Yes ☐ No	☐ Yes ☐ No
Social Relationships	☐ Yes ☐ No	☐ Yes ☐ No
Social Activities	☐ Yes ☐ No	☐ Yes ☐ No
Day to Day Responsibilities	☐ Yes ☐ No	☐ Yes ☐ No

At what age would you say the symptoms began? Please specify:

☐ 0 - 3
☐ 4 – 7
☐ 8 – 12
☐ 13 – 15
☐ 16 – 18

Please check any areas that are or were part of your child's life:

☐ Difficult Birth
☐ Family Member with a Chronic Illness
☐ Death in the Family
☐ Major Loss
☐ Remarriage of a Parent
☐ Physical or Mental Disability
☐ Alcohol/Drug Problems in the Family
☐ Moved Frequently
☐ Family Violence
☐ Emotional Abuse
☐ Sexual Abuse
☐ Economic Difficulties
☐ Academic/Learning
☐ Other _____

Has your child been through any recent disruptions or changes?_____

_____

Briefly describe for me what growing up in your family was like for your child:

_____

_____

_____

When did you first notice the problems your child is experiencing?_____

_____

Please check the disorders your child has been treated for in the past:

Disorder	Medications	For How Long?	Counselor	Helpful?
☐ Depression				
☐ Anxiety				
☐ ADHD				
☐ Bipolar Disorder				
☐ PTSD				
☐ Sleep Problems				

Medical Information: Is your child in: ☐ Good Health ☐ Fair Health ☐ Poor Health?

Is your child currently being treated by a doctor or taking medications prescribed by a doctor?
☐ Yes ☐ No
If yes, state the problem or condition(s) your child is being treated for:_____

_____

Physician's Name_____ Telephone _____

What medications is your child currently taking? (please list)

Medication	Dosage	Prescribed by:	Length of Time Taken

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes: ☐ Medical ☐ Psychiatric

Date	Reason	Location/Facility

Does your child have difficulty sleeping? ☐ Yes ☐ No
☐ Falling Asleep ☐ Intermittent Sleep Troubles ☐ Early Morning Awakening ☐Snores Loudly

Does your child have bladder or bowel control problems? ☐ Yes ☐ No
☐ During the Day ☐ During the Night

Does your child have appetite control problems? ☐ Yes ☐ No
☐ Overeats ☐ Undereats ☐ Suspect Eating Disorder

Substance Use:
Please check and describe which of the following substances you are aware your child has used:

Substance Use	Approximate Age of First Use
☐ Alcohol (Beer, wine, whiskey, etc)	
☐ Cannabis (Marijuana, hash, etc)	
☐ Stimulants (Crack, Cocaine, etc.)	
☐ Hallucinogens (LSD, PCP, Acid, etc.)	
☐ Inhalants (Glue, Gasoline, etc)	
☐ Tobacco Products	
☐ Other	

Please describe any additional information which you think would be helpful regarding your child:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family History: Please indicate the psychiatric problems that **may exist** among relatives **that are biologically related to your child.**

Disorder	**Mother**	**Father**	**Siblings**	**Other Biological Relative (specify)**
Depression				
Bipolar Disorder				
Suicide				
Suicide Attempt(s)				
Anxiety Disorder				
Attention Deficit				
Schizophrenia				
Tourette's Syndrome				
Alcohol Abuse				
Substance Abuse				
Inpatient Psychiatric Treatment				
Other Disorder _____				

MENTAL HEALTH EVALUATIONS

Authorization to Obtain/Release Information

Name_____
Last *First* *M.I.*

I authorize Mental Health Evaluations to provide or exchange the following information:

- ☐ Mental Health Evaluation Report
- ☐ Treatment Plan/Recommendations

Information may be exchanged with or released to (e.g., primary care physician, mental health therapist, or other healthcare provider you designate):

Name_____

Address_____

_____

Telephone Number_____

For the purpose of:

- ☐ Provision of Mental Health Evaluation Results and Referral Information
- ☐ Provision of Treatment/Coordination of Treatment/Continuity of Care
- ☐ Other

Information may be released: ☐ Verbally ☐ Written ☐ Fax

Signature of Client:_____Date_____

Signature of Guardian or Representative_____Date_____

Signature of Witness_____Date_____