ASHEBORO
BEHAVIORAL MEDICINE
727 S. Fayetteville St., Ste C
Asheboro, NC 27203
336-625-2073 336-625-2737 (FAX)

Child and Adolescent Intake and Assessment

Name: **Date:**

Who referred you?
What is the reason you are seeing a therapist?

ALL OF THE FOLLOWING QUESTIONS ARE ABOUT THE PERSON WHO IS SEEKING TREATMENT

SYMPTOM CHECKLIST

check all that apply	
___ cry easily	___ anxiety/constant worrying
___ irritable	___ phobias
___ depressed or sad	times when heart races or can't breathe and ___ feel will die
___ withdrawn	___ frequently having repetitive thoughts
___ feel tired/no energy	___ need to have everything in an exact order
___ appetite/weight change	___ engage in repetitive behaviors
___ loss of interest in doing things	___ difficulty making and keeping friends
___ problems paying attention	___ problems starting projects
problems controlling impulsive behavior ___ (ex. Interrupting others, can't wait turn)	do things to get rid of weight (throwing up, ___ using diuretics, excessive exercise)
____ can't sit still	___ frequently angry
___ lies	____ hits other children
__ periods don't need sleep AND not tired	____ runs away from home
__ periods of increased energy	_____ steals
frequently masturbates/is sexually active or engages in sexually inappropriate touching of ___others	____ has been suspended from school
hearing voices, seeing things others don't ___ see	___ hurts animals
___ thoughts of seriously harming someone	__ have been physically abused
currently has thoughts of harming ____ themselves or yourself	__ have been sexually abused

If you have seen a therapist please list the name and address of the provider:
If you have seen a psychiatrist please provide the psychiatrist name and address:
Has the child ever been in a psychiatric unit? ___ **YES** ___ **NO**
Dates and Hospitals :

CURRENT MEDICATIONS

Name	Dose	Prescribed By	Reason for taking it

Please list all known allergies:

Substance Use

Please fill in for all the substances you use

	Daily	A Week	Weekly	Rarely	Never	In Past
Alcohol						
Marijuana						
Cocaine/Crack						
Speed/LSD/Crystal Meth						
Intravenous (IV) Drugs						
Heroin						
Ecstasy						
Inhalants						
Tobacco						

FAMILY PSYCHIATRIC HISTORY

Please Check All That Apply

	SIBLINGS	FATHER	MOTHER	MOTHER'S RELATIVES	FATHER'S RELATIVES
Aggression/Defiance					
Attention/ ADHD					
Impulse Control					
Bipolar Disorder					
Depression					
Anxiety					
Schizophrenia					
Motor or Vocal Ticks					
Rituals (ex. hand washing)					
Obsessions					
Learning disabilities					
Thyroid problems					
Drug abuse					
Antisocial behavior (stealing etc.)					
Huntington's Disease					
Dementia					
Self harm/Suicide					
Other:					

Child/Adolescent's Medical History

Please list all known allergies:

What is the date of last physical?

Please list any medications or substances that the mother took during pregnancy:

How many months into the pregnancy was the child birth?

Were there any complications during the pregnancy or child birth?

If was in NICU, how long _____
Reason:

Circle any of the following that apply

Anorexia at birth	Forceps used during birth	Eating problems as an infant	Poor eye contact
Delayed in crawling	Delayed in walking	Delayed in talking	Problems with potty training
Head banging	Hard to comfort	Stutters	Doesn't adjust to change
Ear infections	Ear tubes	As an infant hard to comfort	Seizures
Hearing problems	Visions problems	Problems w/ motor skills	

Have you ever experienced a head injury? ___**YES** ___ **NO** If yes, describe location of injury, how it occurred, and any medical exams.

Have you ever experienced loss of consciousness? ___ **YES** ___ **NO**

List any current medical problems and the physician who is treating them:

Family Assessment

Siblings:

Name	Age	Gender	Full/Step/Adopted	Where do they live

Who does the child/adolescent currently live with?

If they are living in more than one home, please list everyone they live with in the second home.

Are parents? _____married, _____never married _____separated _____divorced ___ other__

Are you (parents) experiencing marital conflict? _____YES _____NO

If separated or divorced how old was child/teen when you separated/divorced?_____

Who has custody?_____

How often is visitation?_____

If child does not have contact with other parent, How old where they when this happened? _____

Reason other parent doesn't have contact_____

Is the father remarried?_____

Is the mother remarried?_____

Are there any things I need to know about the child's home/family?

How many good friends does your child/adolescent have?

Child/Adolescent Education and Legal Assessment
What is the name of the school you attend?
What grade are you in?
Have you ever been left behind a grade?
What is your favorite subject in school? Least favorite subject?
What are your current grades?
What grades did you make this time last year?
Do you have an IEP? **___YES ___NO** Have you ever been tested at school for a learning disability? **___YES ___NO** If yes, when?
Is your child/adolescent having behavioral problems at school? **___ YES ___ NO** Explain
Any legal concerns? **___YES ___NO** If yes, what?

_____ _____

Parent/Legal Guardian's Signature Date

Patient Information Sheet
Asheboro Behavioral Medicine

DATE COMPLETED _____

Patient Full Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Hm:_____ Wk:_____ Cell:_____ Sex: M ☐ F ☐

Date of Birth: _____ Marital Status: _____ Soc. Sec. #: _____

Employer: _____ ☐ Full-Time ☐ Part-Time

RESPONSIBLE PARTY Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Home: _____ Phone Number: Hm:_____
Wk:_____ Cell:_____

Employer: _____ ☐ Full-Time ☐ Part-Time

Relationship to Patient: _____

PRIMARY CARE PHYSICIAN: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: (___)_____

EMERGENCY CONTACT Name: _____
(Parent or Guardian for Minors)

Phone No: Home: _____ Work: _____

REFERRED BY: _____

Asheboro Behavioral Medicine, PLLC
727 South Fayetteville Street
Asheboro, NC 27203

AUTHORIZATION FOR TWO WAY RELEASE OF PROTECTED INFORMATION

This form is a two way consent form and when completed and signed by me or my legal representative I understand that it authorizes the release of my protected health information to and from the person I delegate below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal or state privacy regulations.

PATIENT: _____ DOB: _____

I, hereby authorize Asheboro Behavioral Medicine, PLLC to release my behavioral health records including if relevant records pertaining to substance abuse/treatment to:

NAME _____

(Of Organization, MD, or School you Are Giving Permission to Release Information To)

ONLY LIST ONE PERSON PER FORM

And I AUTHORIZE: _____

(WRITE SAME NAME AS YOU WROTE ON LINE ABOVE) to release information to Asheboro Behavioral Medicine, PLLC

Indicate any limitations or exclusions to this consent: _____

The purpose of this disclosure is: Provide Continuity of Care: Other: _____

I understand that unless earlier revoked, this authorization will expire one year from the date that I sign this.

I understand that I have the right to revoke this authorization at any time by given written notification to Asheboro Behavioral Medicine, PLLC. However, the revocation will not be effective to the extant that action has been taken in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim. Asheboro Medicine, and its employees, is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

By signing below I indicate that I have read all of the above and understand and agree.

_____ _____

(Patient/Legal Representative) Relationship to Patient

_____ _____

(Date) Witness

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

PLEASE USE A SEPARATE CONSENT FORM FOR EACH AGENCY

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BILLING AUTHORIZATION

I understand that if I do not provide the correct and updated insurance information I will be billed for the session. I also understand that Asheboro Behavioral Medicine has the right to terminate services for non-payment.

_____ _____

Signature Date

I agree to have Asheboro Behavioral Medicine submit claims to insurance agencies on my behalf. I understand that I am responsible for payment of services and claims not covered by my insurance.

_____ _____

Signature Date

I DO NOT agree to have Asheboro Behavioral Medicine submit claims to insurance agencies on my behalf. I understand that I am responsible for payment for all services and failure to do so gives Asheboro Behavioral Medicine the right to terminate services.

_____ _____

Signature Date

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EMERGENCY CONTACT & APPOINTMENT REMINDERS

We are currently trying to remind people of their appointments. There are also times that we may need to reach you for other reasons or to reschedule an appointment due to an unforeseen emergency or illness. It is helpful if we have all of your current contact information so that we can provide better service to you. Please let us know if anything changes. Thank you.

Patient's Name_____ DOB:_____

Parent/Guardian's Name (If patient is a minor) _____

HOME PHONE_____Is it Ok to leave a msg? _____Yes _____No

WORK PHONE_____Is it Ok to leave a msg? _____Yes _____No

CELL PHONE_____Is it Ok to leave a msg? _____Yes _____No

Which Number is best to reach you at during the day?

Home Work Cell

Which number is best to reach you at night? (after what hour usually?_____

Home Work Cell

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HIPPA CONSENT FORM

FOR THE SECURITY AND DISCLOSURE OF PROTECTED HEALTH INFORMTION

TO OUR PATIENTS:

Patient information will be maintained by Asheboro Behavioral Medicine as described by the Notice of Privacy practices available upon request by asking your therapist in compliance with federal and state regulations.

Asheboro Behavioral Medicine reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone that you may elect in writing to receive it. We will release information related to work related injury to your employer.

We reserve the right to:

- Call you to remind you of your next appointment and leave information on your answering machine

If there is anyone that you would like us to share your health information with please provide their names below:

_____

_____

_____

I have read and understand my rights:

_____ _____

Client or Legal Guardian's Signature Date

_____

Witness

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TO OUR PATIENTS:

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Asheboro Behavioral Medicine reserves the right to release your healthcare information based upon a decision by your psychologist for medical emergency situations and in general for continuity of care.

We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations.

We will release your information to anyone that you may elect in writing to receive it. We will release information related to work related injury to your employer.

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LIMITS OF CONFIDENTIALITY

PATIENT'S COPY

In general, the privacy of all communications between a patient and a psychologist/therapist is protected by law, and we can only release information about our work to others with your written permission. No one outside of Asheboro Behavioral Medicine can have access to the information in your file without your consent except under the following circumstances:

1. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

2. There are some situations in which we are legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we are required to file a report with the appropriate state agency.

3. If we believe that a patient is threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

4. Asheboro Behavioral Medicine reserves the right to release your healthcare information based upon a decision by your therapist for medical emergency situations and in general for continuity of care.

5. We reserve the right to dictate notes and letters. The person that does the transcription is trained in the laws governing Confidentiality and cannot reveal anything contained in the transcripts

6. For purposes of covering call information is shared with Asheboro Counseling who is governed by the same statutes governing Confidential Information.

7. We may occasionally find it helpful to consult other professionals about a case. During a consultation, we make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential.

8. If you choose to use health insurance, you must sign a release so that we can release required information to your billing company. While health insurance companies are also bound by confidentiality, Asheboro Behavioral Medicine is not responsible for the protection of your information when the insurance company possesses it.

9. When working with adolescents and children we keep all information discussed in session confidential unless we feel that the child or teen is engaging in a practice that will put them at risk. As a parent or guardian, you are agreeing by your signature below, that you waive all rights under law to the contents of your child/ren's charts and notes.

10. In the course of couples/family therapy, occasions arise where one or the other participant may have an individual therapist. Asheboro Behavioral Medicine reserves the right to release to the individual's therapist that information which may benefit that individual with the consent of that one party.

If these situations occur, we will make every effort to fully discuss it with you before taking any action. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Client's Signature Date

_____ _____

Legal Guardian's Signature Date

_____ _____

Therapist Date
Asheboro Behavioral Medicine