Behavioral Wellness Center of South Florida, LLC

7100 W Camino Real, Ste, 203

Boca Raton, FL 33433

PATIENT INFORMATION (Child/Adolescent):

Child's Name: ____________________________________

Mother's Name: _____________________ Father's Name:________________________

Legal Guardian's Name (if applicable): ____________________________

Date of Birth: ______________ Age: _____________ Sex: M ____ F____

Address: __________________________________

____

____

Phone: Home:_______________________ Parent's Work: _____________________

Parent's Cell: ________________________ Child's Cell: ___________________________

Parent's Email: _______________________ Child's Email: __________________________

School: __________________________ School Phone: ______________________

Grade: ________ If special education, please specify: _______________________

Primary Care Physician: __________________________ Phone: _________________

Name of person/s who referred you: ____

Phone Number: ______________ Address: _______________________________________

Email: _____________________________

……………………………………………………………………………………………

FAMILY INFORMATION

Please list all individuals who are currently living in child's primary residence:

Name/ Relationship to Child/ Age

____

____

____

____

____

Mother's Occupation: ____

Father's Occupation: ____

Child's parents are (circle):

married/domestic partners   divorced   separated   never married

If divorced or separated, who has legal/physical custody? __________________________

Have there been any deaths of /separations from family members or friends with whom patient was close or had frequent contact? If so, please explain (include dates, relationship to child):

____

____

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____

Have any family members had emotional or psychiatric problems? Y/N

If yes, who? What was the nature of the difficulties? Was treatment sought?

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____

____

……………………………………………………………………………………………

DEVELOPMENTAL / MEDICAL HISTORY

Pregnancy/Delivery/Developmental History:

Please list any complications the child's mother had during pregnancy:

____

____

____

Complications during delivery:

____

____

____

Child was born (circle):

pre-term by #_______days on time post term by #_______days

At what age did your child achieve these developmental milestones?

Crawling: _________ Walking: _________

Toilet Training: ________ Talking (single words):________ (sentences):________

Any problems during the first year?

Excessive Crying Y/N Hyperactivity Y/N

Feeding Problems Y/N Underactivity Y/N

Please describe sleep patterns at the present time: _____________________________________

____

Other important information about your child's development:

____

____

____

Has your child ever experienced a traumatic or significantly upsetting event?

____

____

Medical Issues:

Please list your child's medical problems (from infancy to present time):

____

____

____

Hospitalizations / Surgeries:

Dates Reason for Hospitalization / Surgery

____

____

Current Medications:

__________________________________ ______________________________

__________________________________ ______________________________

……………………………………………………………………………………………

EDUCATION

Has your child ever skipped/repeated (please circle) a grade? If so, when? _________________

Does your child receive special services in school? ____________________________________

Last date of IEP: _______________________

Has your child been diagnosed with a learning disability Y/N? __________

PREVIOUS/CURRENT PSYCHO-SOCIAL TREATMENT

Has your child ever received mental health treatment? Y/ N

Is your child currently receiving mental health services of any kind? Y / N

Please list all present and previous mental health services received below in chronological order:

Mode of Treatment/ Dates/ Reason for Treatment

Outpatient psychotherapy:

Individual

____

Family/Couple

____

Group

____

Other

____

Psychiatric Hospitalizations ____

____

____

Psychotropic Medications ____

____

Other Forms of Treatment

____

If your child is currently on psychotropic medication, please write the name and phone number of the psychiatrist or doctor who prescribes it:

____

………………………………………………………………………………………………

REASON FOR REFERRAL

Describe why you are seeking treatment for your child/adolescent. When did these difficulties begin? Did any specific event occur prior to onset?

____

____

____

____

____

Please check off any of the following problems with which your child is currently struggling:

_____ sad/depressed mood	_____ Increased sleep	_____ Purging
_____ anxious	_____ Decreased sleep	_____Physical Aggression
_____ Panic Attacks	_____ Nightmares	_____ Truancy
_____ Angry Outbursts	_____ Drug Use	_____ Suicidal thoughts
_____ Withdrawn	_____ Poor attention	_____ Suicide attempt
_____ Fatigue	_____ hyperactivity	_____ Self injury (i.e. cutting)
_____ Decreased appetite	_____ Stealing	_____ Poor family relationships
_____Increased appetite	_____ Alcohol/drug use	_____ Poor peer relationships
_____ Excessive weight gain/loss	_____ Difficulty sleeping through the night	_____ inappropriate sexual behavior

Please use this space to describe any other problems, questions, or concerns you have about your child/adolescent.

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____

AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION

DATE:

I, ____________________________, give permission for psychologist, Dr. Michelle W. Greenberg at Behavioral Wellness Center of South Florida, LLC, to discuss my child's (Name of Child: __________________________) information and treatment (includes any pertinent psychological and medical background information and current issues) with the following parties:

1. Name: _____________________________ Affiliation: ______________________

Address: ____

Phone Number: ____

2. Name: ______________________________ Affiliation: _______________________

Address: ____

Phone Number: ____

3. Name: ______________________________ Affiliation: _______________________

Address: ____

Phone Number: ____

I understand this authorization will expire at termination of treatment or at any time prior upon written request. I hereby consent that this communication can take place through:

____ telephone _______ fax ______ email ______ mail

I understand that email is not a confidential method of communication and that there is a risk that email communications may be intercepted by a 3rd party or may be transmitted to unintended parties. I am aware that Dr. Michelle W. Greenberg will take all necessary measures to avoid using identifying information in email communications.

Date: ____________________

Name of Authorized Patient Representative (Print): ______________________________

Signature of Authorized Patient Representative: _________________________________

Authorized Representative's Relation to Patient: ________________________________

Name of Party Accepting Authorization (Print): _________________________________

Signature of Party Accepting Authorization: ____________________________________