NewPoint Behavioral Health Care

APPLICATION FOR SERVICES – CHILD

FOR CENTER USE ONLY

CLIENT NUMBER: _____

CHECK ONE		*COMPLETE*
__ Outpatient	__ Ch. Partial Care	Fee: _____
__ Screening	__ Other (specify) _____	Medicaid #: _____
__ Ch. Case Mgmt		Intake Date: _____
		Staff/Degree: _____

__ Check here if Client information has been updated on back

Date: _____ Child's Date of Birth: _____

Name of Child: _____ SS#_____-_____-_____
Last First Middle

Address: _____
Number & Street Town State Zip Code

Phone: _____ Emergency Phone # _____ Gender_____ Race/Ethnicity _____

Parent's Occupation: _____

Parent's Place of Employment: _____Phone #: _____

Annual Household Income: $_____ Total # of persons dependent on income _____

Name of School Attending: _____ Grade: _____

PEOPLE LIVING IN YOUR HOME

NAME	RELATIONSHIP	BIRTHDATE	OCCUPATION	EDUCATION

Name and address of family doctor: _____

Who suggested that you come to the Center? _____

What problem brought your child to the center? (be somewhat specific):

How long has the problem been going on: _____

Has your child ever been classified and, if so, what was the classification? _____

Has your child ever had a child study team evaluation done and, if so, when and by what school?
_____

Has your child ever repeated any grade? ☐ yes ☐ no If yes, what grade? _____

If your child does not attend school, is he/she employed? _____ If yes, please describe _____
_____
_____

When was your child last examined by a physician? _____

Please list any major health problems/allergies for which your child is currently receiving treatment:
_____
_____

Please list any past major illnesses, operations or injuries: _____
_____

List any medications your child is now taking: _____
_____

How is your child's appetite? _____

How is your child's sleep? _____

Did anything unusual happen during pregnancy with this child (e.g. spotting, extreme nausea, need for medications (prescription or over the counter), need for bed rest, etc.) or were any drugs or alcohol used during pregnancy?
_____
_____

Was this a full term pregnancy? ☐ yes ☐ no

Was there anything unusual about the birth and the period just following (e.g. forceps, oxygen deprivation, Caesarian, jaundice, measles, sustained high fever, etc) If so please explain: _____
_____

Does the child have difficulty making friends? ☐ yes ☐ no If yes, please explain: _____
_____

How would you describe the child as a person? _____
_____
_____

In what way would you like the Center's help? _____
_____
_____
_____

Has the child ever been to this Center before? ☐ yes ☐ no. If yes, when? _____

Has a member of your family ever been to this Center? ☐ yes ☐ no. If yes, when? _____

Has the child ever received mental health services from a hospital, clinic or private source before? ☐ yes ☐ no

If yes, please give the name(s) and location(s):
_____
_____
_____
_____

Has the child ever received services for substance abuse (drugs and/or alcohol) before? ☐ yes ☐ no

If yes, please provide information as to where and when: _____
_____

Any additional information you would like us to know? _____
_____
_____
_____

NOTE: Fees for service are based on a sliding scale. Since the cost of providing services exceeds public funding, the difference must be covered as fully as possible by the applicant.

HMO MAY NOT COVER CENTER SERVICES. SOME COVERAGES MAY REQUIRE A CO-PAY

What health insurance do you have? _____
Company Name and Phone number, if known

Insurance ID number: _____

I have received copies of "Client Rights" and "How to Report a Complaint" and have had an opportunity to discuss them.

_____
Parent/Guardian or Client (if age 14 or older) Signature

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Please use this space for updating client information such as change of address, phone number, etc.

_____
New Address # and Street City State Zip

_____
New telephone # Other updated information