Community Care Programs, Inc.

Outpatient Behavioral Health Clinic

Screening Intake Agency

Thank you for your referral. We appreciate your trust in our agency and we will attempt to provide excellent services to you and your youth. Please complete our form and return it to our agency.

NOTE: Please submit a copy of BOTH sides of the insurance card

CLIENT INFORMATION

Child's Name:_____ Age:_____ DOB:_____ Identifies as: ☐ Male ☐ Female

Client Lives with: _____ Relationship:_____

Address: _____
Street Address *City* *ZIP Code*

Phone: _____ Email:_____

School: _____ Grade:_____

Medical Assistance #: _____ ☐ Not Applicable

Legal Guardian/Signatory: _____ ☐ Not Applicable

Address: _____
Street Address *City, State* *ZIP Code*

Phone: _____ Email:_____

Parent/Guardian(s): _____

Address: _____
Street Address *City, State* *ZIP Code*

Phone: _____ Email:_____

Parent/Guardian(s): _____

Address: _____
Street Address *City, State* *ZIP Code*

Phone: _____ Email:_____

Placement History:

COUNTY INFORMATION

County/Agency: _____ Phone: _____

Referring Worker: _____ Email: _____

Supervisor: _____ Email: _____

BILLING INFORMATION

☐ Insurance*: _____ *Please submit a copy of **both sides** of the Insurance card

☐ MA (Badger Care)

☐ CCS - County: _____

☐ Financial agreement with client's parent/legal guardian

☐ Service pricing agreement with County

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Phone: _____

PRESENTING ISSUES

Primary Concern:

Secondary Concern: _____

Other Concerns: _____

Current Symptoms/Problems: *please check all that apply*

☐ Aches & Pains	☐ Elevated mood	☐ Irritable	☐ School problems
☐ Angry	☐ Fears	☐ Learning difficulties	☐ Self-harm
☐ Anxious	☐ Gang involvement	☐ Neglect victim	☐ Sex offending
☐ AODA	☐ Hears voices	☐ Panic attacks	☐ Sexual abuse survivor
☐ Appetite disruption	☐ Hopeless	☐ Paranoid	☐ Sexualized talk/behavior
☐ Avoids talking about problems	☐ Hyperactive	☐ Peer problems	☐ Shut down
☐ Bad dreams	☐ Hyper vigilance	☐ Physical abuse survivor	☐ Sleep difficulties
☐ Defiant	☐ Impaired concentration	☐ Physical Aggression	☐ Suicidal
☐ Depressed mood	☐ Impaired memory	☐ Police contact	☐ Traumatic play
☐ Domestic violence	☐ Impulsive	☐ Running away	☐ Verbal aggression
☐ Eating disorder	☐ Other: _____		

MENTAL HEALTH/TREATMENT

Diagnosis: _____

Previous Therapy

Provider Name: _____ Phone: _____

Dates: _____ ☐ Individual ☐ Family ☐Group

Provider Name: _____ Phone: _____

Dates: _____ ☐ Individual ☐ Family ☐Group

Current Therapy

Provider Name: _____ Phone: _____

Dates: _____ ☐ Individual ☐ Family ☐Group

Has child had any evaluations? *please check all that apply*

☐ Psychological Provider: _____ Date: _____

☐ Psychiatric Provider: _____ Date: _____

☐ Other: _____ Provider: _____ Date: _____

Medical History

Significant Medical History: ☐ Yes ☐ No Please explain: _____

Allergies: *(food, meds, environmental)* ☐ Yes ☐ No Please explain: _____

Asthma: ☐ Yes ☐ No Please explain: _____

Encopresis/Enuresis: ☐ Yes ☐ No Please explain: _____

Head Injury: ☐ Yes ☐ No Please explain: _____

Seizures: ☐ Yes ☐ No Please explain: _____

Fetal Alcohol Syndrome: ☐ Yes ☐ No Please explain: _____

Prenatal substance exposure: ☐ Yes ☐ No Please explain: _____

Medications *(please list)*: _____ Dosage: _____

_____ Dosage: _____

_____ Dosage: _____

_____ Dosage: _____

Prescribing Provider(s): _____ Contact Number(s): _____

_____ Contact Number(s): _____

_____ Contact Number(s): _____

_____ Contact Number(s): _____

Additional Comments/Notes: