Today's date: ______________________________ PCP: ____

Patients name: ____________________________ Referring provider: ____

DOB: _____________________________________ Insurance:

Form completed by:________________________ Relation:_______________________ Phone # ___________________

Please complete this form in as much detail as possible

Thrive Behavioral Health Child Intake Form

Please check all that apply to your child:

Current Behaviors (past 30 days)

- ☐ Threats of killing or hurting self
- ☐ Threats of killing someone else
- ☐ Hear or see things others do not
- ☐ Self-injury
- ☐ Fire setting
- ☐ Bed wetting
- ☐ Stealing
- ☐ Argumentative
- ☐ Avoidance of responsibility
- ☐ Secretive
- ☐ Irritable
- ☐ Racing thoughts
- ☐ Over-tired/easily fatigued
- ☐ Eating problems
- ☐ Oppositional behavior
- ☐ Hurting animals
- ☐ Unable to keep friends
- ☐ Day wetting
- ☐ Worries
- ☐ Tearful
- ☐ Angry mood
- ☐ Vandalism
- ☐ Lying
- ☐ Frequent physical complaints
- ☐ Nightmares
- ☐ "Flash-Backs"
- ☐ Blames others
- ☐ Sexual acting-out
- ☐ Repetitive behaviors
- ☐ Hyperactivity
- ☐ Exaggerated sense of worth
- ☐ Hopelessness
- ☐ Drug/alcohol abuse
- ☐ Mood swings
- ☐ Frequent conflict
- ☐ Fearful
- ☐ Poor decisions
- ☐ Sad
- ☐ Delinquency
- ☐ Extreme shyness
- ☐ Recurring thoughts
- ☐ Hard to remember things
- ☐ Difficulty with concentrating
- ☐ Social isolation
- ☐ Panic attacks
- ☐ Crisis situation
- ☐ ED visit
- ☐ Use of crisis services
- ☐ Suicidal ideation
- ☐ Suicide attempt
- ☐ Difficulty sleeping
- ☐ Exposure to traumatic event:
  Example(s):___________________
  ____
  ____
  ____

Developmental History Please check all that apply:

- ☐ Difficulties/abnormalities during pregnancy
- ☐ Medication during pregnancy
- ☐ Walking/gross motor difficulties
- ☐ Difficulties during pregnancy
- ☐ Excessive fears
- ☐ Difficult to comfort
- ☐ Exposure to drugs or alcohol during pregnancy
- ☐ Speech/Language problems
- ☐ Eating non-foods
- ☐ Fine motor problems
- ☐ Overly friendly
- ☐ Exposure to lead
- ☐ Poor attachment to parents/caregivers
- ☐ Problems eating as a baby
- ☐ Problems sleeping as a baby
- ☐ Away from parents for a long time
- ☐ Premature at birth
- ☐ Underweight at birth
- ☐ Did not meet developmental milestones on time
- ☐ Neglect

Experiential History Please indicate what the child has experienced in life until now:

- ☐ Death in the family
- ☐ Crime victim
- ☐ Violence in home
- ☐ Parental illness
- ☐ Emotional abuse
- ☐ Parental divorce
- ☐ Parental/guardian separation
- ☐ Police confrontation
- ☐ Witness to drug abuse
- ☐ Witness to domestic violence
- ☐ Fights at school
- ☐ Poor grades
- ☐ Good grades
- ☐ Other academic concerns

☐ Alcohol/drug abuse (by whom and when)______________________________

☐ Sexual or physical abuse (by whom and when) ______________________________

☐ Known family history of physical or sexual abuse (by whom and when) ______________________________

☐ DHS involvement ______________________________

Please tell us about your family history and current family situation.

Who is in the home? If your child has multiple homes please list all members in all households.

Tell us about events that have happened in this child's life that may impact how they function now.

Does your child want to see a therapist or are they willing to see one?

Please give a detailed description of the current situation and the reasons you are seeking support.

Are family members willing to do family therapy? If so, what family members would you like to be involved in therapy to support the child?

____

Signature (Parent) Signature (Child)

Do you have specific characteristics that you are looking for in a therapist?
(Personality, gender identification, expertise, etc.)

Is your child taking any medications, vitamins or supplements?

Has your child attempted suicide in the last 30 days? If so, please explain.

Has your child ever attempted suicide? If so, please explain.

Overall family-life growing up is/was check all that apply:

- ☐ Supportive
- ☐ Loving
- ☐ Chaotic
- ☐ Confusing
- ☐ Affirming
- ☐ Strict
- ☐ Hostile
- ☐ Safe
- ☐ Unsafe
- ☐ Negative

- ☐ Has the child or any family member had counseling before? If yes, please list the dates, with whom, and for what purpose.
- ☐ Has anyone in the family ever seriously considered or attempted suicide? If so, please explain whom, the circumstances, and when this took place.
- ☐ Has the child or any immediate family member currently taking any type of medication? If so, please list the medication, purpose, and the prescribing physician.
- ☐ Custody or parenting conflicts? If yes, please provide the most CURRENT custody or parenting agreement that is in place.

Please read and initial the following:

_ I understand my child may be referred to Specialty Services, should he or she need a higher level of care.

_ I understand that my counselor IS NOT available for crisis intervention or emergencies.

_ In case of an emergency, please call 911.

_ If suicidal, please take the child to the Emergency Room.

____

Signature (Parent) Signature (Child)

Please list 3 Goals:

1. ____

____

2. ____

____

3. ____

____

This completed form will be reviewed by our case management team. Once it has been reviewed and determined to be a good fit for Thrive Behavioral health, it will be sent to specific therapists for review. Our goal is to connect your family with a therapist that is the best fit for you based on your needs. Thrive Behavioral Health does have a waiting list. You are always welcome to call Thrive Behavioral Health or Eugene Pediatric Associates and as to speak with a case manager to find out where your child is on the wait list.
If we need further information we will reach out to you.

What is the best way to reach you if we need to?

Phone or email? (Circle one and please list best phone number or email address below)

____

Signature (Parent) Signature (Child)