1300 Mercantile ln
Ste 129-2 Largo MD 20774
Phone (301) 272-1055
Fax (301) 272-1056

Phone (301) 272-1055

PATIENT REGISTRATION:

First: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Social Security #: _____

Birth Date: _____ Age: _____ Gender: _____ Marital Status: _____

Race: _____ Email: _____

EMERGENCY CONTACT: NAME _____ **PHONE:** _____

Legal Guardian Information (If patient is less than 18 years old)

Legal Guardian Name: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____ Work #: _____

Financial and Policy Holder Information

Primary Insurance

Insurance Company: _____ Contract #: _____ Group #:

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Phone #: _____ Sex: ☐M or ☐F

Secondary Insurance

Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Phone #: _____ Sex: ☐M or ☐F

Behavioral Health Intake Form – Child & Adolescent

	Today's Date
Child's Name	Date of Birth
Address	
City State	ZIP Code
Primary Telephone:	☐ home ☐ cell ☐ work
Alternate Telephone:	☐ home ☐ cell ☐ work

We were referred by:

Household Composition

Who lives in the primary residence with the child?

Name	*Age*	*Relationship to Client*	*Name*	*Age*	*Relationship to Client*

Does the child live in a second home? ☐ Yes: How often? ☐ No

Name	*Age*	*Relationship to Client*	*Name*	*Age*	*Relationship to Client*

Parents' Marital Status/Family of Origin

☐ Never Married	☐ Is the child adopted? If so, is child aware?
☐ Married/Civil Union	Siblings names & ages:
☐ Separated, when:	
☐ Divorced, when:	
☐ Widowed, when:	Other significant relationships:
☐ Remarried, when:	

Current Medications

Medication	Dates	Reason	Effectiveness

Child's Medical History		
☐ Asthma	☐ Bowel problems	Allergies:
☐ Recurrent ear infections/tubes	☐ Thyroid disease	
☐ Eye/Vision problems	☐ Diabetes (Type I/Type II)	
☐ EEG, MRI, or CT	☐ German Measles, Whooping Cough, Measles, Mumps, Scarlet Fever, Chicken Pox	Hospitalization:
☐ Headaches/Migraines		
☐ Meningitis/Encephalitis		Surgery:
☐ Seizures	☐ Lead/Toxic chemical exposure	
☐ Head injury/Concussion	☐ Irregular menstrual period	Other:
☐ Developmental delay	☐ Pregnant	
☐ Slow weight gain	☐	

Please check all that that have applied to your child in the past 30 days:		
☐ Can't concentrate/Pay attention	☐ Bedwetting/soiling self	☐ Sees/hears things that are not real
☐ Restless/Hyperactive	☐ Has been bullied	☐ Confused thinking
☐ Talks too much/out of turn	☐ Frequent sadness/irritability	☐ Feels people are "out to get" him/her
☐ Impulsive/Acts without thinking	☐ Tearful/Cries easily	☐ Odd/bizarre thoughts/behavior
☐ Trouble staying seated	☐ Low energy level	☐ Behaves like a younger child
☐ Makes careless mistakes	☐ Loss of interest in favorite activities	☐ Has trouble communicating
☐ Fails to finish things he/she starts	☐ Low self-esteem/Guilt	☐ Sensory experiences/issues
☐ Feeling irritable	☐ Dislike of his/her body	☐ Makes repetitive sounds/movements
☐ Daydreams/Gets lost in thought	☐ Feelings hurt easily	☐ Fascinated with parts of toys
☐ Inattentive/Easily distracted	☐ Has trouble making & keeping friends	☐ Is not affectionate
☐ Has trouble following directions	☐ Severe changes in mood	☐ Lack of imaginary/pretend play
☐ Forgetful/Often loses things	☐ Talks too much/fast/changes topic quickly	☐ Avoids/seems obsessed with certain things
☐ Police contact		
☐ Angry/Resentful	☐ Thoughts racing	☐ Does not seek to share interests
☐ Argues/Does not follow rules	☐ Inflated self-esteem	☐ Does not make friends/is in own world
☐ Annoys others purposely	☐ Difficulty controlling emotions	☐ Does not keep eye contact
☐ Bullies/Threatens/Intimidates	☐ Worries about safety of self/others	☐ Rituals/routines must be followed
☐ Physical aggression	☐ Unusual worries/fears	☐ Needs little sleep (rested after 3-4 hours)
☐ Has set fires	☐ Panic attacks	☐ Cannot fall asleep even though tired
☐ Stealing/Shoplifting	☐ Obsessive thoughts	☐ Problems staying asleep/Nightmares
☐ Temper tantrums/Loses temper easily	☐ Panics when separated from parent	☐ Unable to care for hygiene/nutrition/basic needs
☐ Lies/Blames others for own misbehavior	☐ Unusual behaviors dressing, bathing, mealtime, or counting rituals	☐ Nervous tics or other repetitive, abrupt nervous movements or vocal noises
☐ Cruel to animals	☐ Picky eater	☐ Grief/Loss
☐ Violates curfew/Has run away	☐ Self-injury/Cutting/Burning	☐ LGBTQ concerns
☐ Suspected alcohol/drug use	☐ Suicidal thoughts/threats/actions	☐ Friendship/Relationship problems
☐ School suspensions/Alternative school	☐ Witness to domestic violence	Other:
☐ Inappropriate sexual activity	☐ History of physical abuse	
☐ History of unwanted sexual contact	☐ History of sexual abuse	

CHILD INTAKE FORM
(Please complete in Ink)

CHILD

1. Child's Name_____Sex_____Age_____DOB_____
2. Natural Child Yes / No If adopted, at what age_____ Foster since _____
3. Parent's Names (include step-parents, foster parents, inc.)

_____

_____

4. Comments about custody and visitation (if applicable):

_____

_____

5. Primary reason you are concerned about your child?

_____

_____

_____

SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern. How long has it been a problem?

a.
_____ Sleep problems
_____ Lack of interest in activities
_____ Unassertive
_____ Fatigue/low energy
_____ Concentration problems
_____ Appetite/weight changes
_____ Withdrawal

_____ Morbid thoughts
_____ Suicidal thoughts or threats
_____ Suicidal plans / attempts
_____ Mood swings
_____ Depression
_____ Changed level of activity
_____ Cries easily

b.
_____ Forgetful/memory problems
_____ Short attention span
_____ Aggressive behavior
_____ Can't sit still
_____ Not interested in peers
_____ Picked on / bullied by peers

_____ Talks excessively / interrupts
_____ Easily distracted
_____ Irritable
_____ Impulsive
_____ Difficulty following rules
_____ Problem completing schoolwork

c.
_____ Excessive worry / fearfulness
_____ Anxiety or panic attacks
_____ Social fears, shyness
_____ Separation problems
_____ Bedwetting / soiling
_____ Headaches, stomachaches
_____ Odd beliefs / fantasizing
_____

_____ Nightmares
_____ Frequent tantrums
_____ Resistive to change
_____ School refusal
_____ Perfectionism
_____ Odd hand / motor movements
_____ Hallucinations
_____

d.
_____ Lying
_____ Trouble with the law
_____ Running away
_____ Truancy, skipping school
_____ Hurting others sexually
_____ Alcohol / drug use
_____ Argumentative / defiant
_____ Swears
_____ Blames others for mistakes

_____ Stealing
_____ Being destructive
_____ Fire setting
_____ Hurting others / fighting
_____ Acts as if has no fear
_____ Short tempered
_____ Easily annoyed / annoys others
_____ Discipline problem
_____ Angry and resentful

Brothers and Sisters

First Name – Last Name	Sex	Age	Relationship to child (full, step, half, foster)
1.			
2.			
3.			
4.			
5.			
6.			

SCHOOL HISTORY

1. Present School: _____ Grade: ____ Teacher:_____

2. Has child ever repeated any grade? _____

3. Is child in special education services? No ____ Yes, what kind? _____

4. Please describe academic or other problems your child has had in school

_____

CHILD'S DEVELOPMENTAL AND MEDICAL HISTORY

1. **Pregnancy**

Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal _____ Breech _____ Cesarean _____ Transectional _____
Full-term _____ Premature _____ if premature, number of weeks _____

Birth Weight: _____

Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an Incubator, etc)

_____

2. **Developmental History**

- State approximate age when child did the following:

  Walked alone _____ Said first word _____ Used 2-word phrases _____

- Understood and followed simple directions _____
- Reasonably well toilet trained _____
- Did child cry excessively? _____ Rarely cried _____

3. **Health History of Child**

In the first two years, did your child experience: ___Separation from mother, ___Out of home care, ___Disruption in bonding, ___Depression of mother, ___Abuse, ___Neglect, ___Chronic pain, ___Chronic Illness, ___Parental Stress

- Child's Doctor: _____
- Date of last physical exam: _____
- Vision problems? Yes _____ No_____ Hearing problems? Yes _____ No _____
- Dental problems? Yes ____ No ____
- Any head injuries or loss of consciousness? Yes _____ No _____
- Child's history of serious illness, injury, handicaps, or hospitalization?

  No _____ Yes – describe and give dates _____

- Is your child currently taking any medications? No ____ Yes ____ name medications

_____

- List any medicines previously used for emotional problems: were they helpful? ____

  _____

- Allergies to drugs or medicines? No ____ Yes ____ (list) _____
- Allergies to any foods? No ____ Yes ____(list) _____
- Are there any foods that you limit or do not give this child? No ____ Yes ____

  (list) _____.
- Allergies to environmental conditions? No ____ Yes ____(list) _____
- Does anyone in the household smoke? No ____ Yes ____
- About how many hours does this child watch TV, videos, etc per day _____
- Are you afraid someone you know may injure/harm this child? No ____ Yes ____

  National Domestic Violence Hotline 1-800-799-7233
- Does this child have a Health Care Directive? No ____ Yes ____

  If yes, please list where (clinic) it is on file _____
- Any previous psychological or psychiatric treatment? No _____ Yes _____

  Whom/where _____when_____
- Any previous testing (school/psychological)? No _____ Yes _____

  Whom/where _____when_____
- Do you think your child's use of chemicals is a problem? No _____ Yes _____

  Type: Alcohol _____ Marijuana _____ Other drugs _____

  Comments: _____

Family History:

Chemical use (now & past): No _____ Yes _____ Which parent _____

Type: Alcohol _____ Marijuana _____ Other drugs_____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

_____

_____

Has child witnessed domestic violence? __Y, __N, Specify: _____

_____

How is your child disciplined? Please list each method and frequency of use: _____

_____

_____

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify: _____

_____

2. Has your child been physically abused? __Y, __N, __Suspected. Specify: _____

_____

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify: _____

_____

4. Other stressors or traumas? _____

_____

What are your child's strengths?

Asten Behavioral Health

PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by **Asten Behavioral** (hereinafter referred to as "**ABH**") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of BH.

Health I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. ABH is not required to agree to the restrictions that I may request. However, if ABH agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that ABH has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ABH 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of ABH. The Notice of Privacy Practices also describes my rights and ABH 's duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

ABH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by email or asking for one at the time of my appointment.

Initial _____ **Date** _____

Asten Behavioral Health

EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse
- The client is required to undergo a court-ordered examination
- The client discloses information about abuse, neglect, or exploitation of a minor
- The client discloses information about abuse, neglect, or exploitation of an aged or disabled adult
- The client's mental or emotional condition is used as a legal defense
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action

I hereby give my consent for service to be provided under these conditions.

Asten Behavioral Health INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I can discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or inter, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

Initial _____ **Date** _____

Asten Behavioral Health

AUTHORIZATION FOR CONTACTING PATIENT

Should a circumstance arise when it becomes necessary for the office to call you for any reason (such as to verify or change your appointment), every effort will be made to notify you in a timely manner. Please indicate your preference for being contacted.

☐ Telephone Yes No (Circle One) HOME # _____
☐ Telephone Yes No (Circle One) WORK # _____

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

INFORMATION FOR CLIENTS

Our Practice

We are a group of licensed mental health professionals in private practice. We see clients by appointment only. Appointments are scheduled according to the individual doctor/therapist recommendation. If there is an emergency during office hours, which requires immediate attention, please contact the office by phone. If an appointment cannot be kept, please contact the receptionist at least 24 hours in advance. There will be a ***$50 service charge for late cancellations and a $50 service charge for no shows.*** You are responsible for this fee and your insurance companies **WILL NOT** pay for this fee. If unforeseen circumstances arise and you are able to give notice that is less than 24 hours we will do our best to fill the vacancy. If we are able to do so, you will not be charged. The more notice you can give the better we are to accommodate other patients who need to be seen.

Confidentiality

Communications between the provider and the patient are strictly confidential and protected under Maryland Law and by the ethics of our profession. In order to communicate with others about your case, your provider must have permission in writing. Our registration form and our Notice of Privacy Practices explain the limits of confidentiality.

After Hour Emergencies

Our telephone number is **301-272-1055** If you need to speak with your doctor or therapist, please make your calls brief. Calls of more than 5 minutes will be billed at the provider's hourly rate. Calls are answered 24 hours each day, 7 days a week. After office hours, you can leave a message on the voice mail or in an urgent situation; leave a message with the answering service operator who will contact your doctor/therapist/provider or the person on call. You may leave a voicemail or call during business hours for all prescription refill request or appointment change/cancellation request. **If immediate services are required or you have an emergency, please call 911 or go to the nearest Emergency Department.**