WEST BERGEN MENTAL HEALTHCARE
APPLICATION FOR TREATMENT SERVICES – Child

Today's Date:_______________ Name of Client:____

Date of Birth:_______________ SS#:________________________ How did you hear about West Bergen?_______

____

Address:____

Street City, State, Zip Code

Home Phone:______________________ Cell Phone:________________________Bus. Phone:________________

E-mail (optional):____

Client's Education Level:

Grammar School_________ High School________ College _______ Post-Grad___________

Client's Marital Status:

Never Married/Minor Child____ Married___ Separated____ Divorced____ Widowed____ Domestic Partner____

Client's Ethnicity:

American Indian/Alaskan___ Asian/Pacific Islander___ African American___ Hispanic___ White___ Other_____

Client's Sex: Male____ Female____

(To be filled out, if applicable)

Parent/Guardian #1

Name:____ SS#:_____________________ DOB:_____________

Home Address & Phone: (if different from above)____

Parent/Guardian #2

Name:____ SS#:_____________________ DOB:_____________

Home Address & Phone: (if different from above)____

Parents'/Guardian Marital Status:___________________________

Please list every member of your household:

Name	Date of Birth	Sex	Ethnicity (if different from above)	Relationship

Insurance Information: Policy Holder's Name:____________________________________

Insurance Company: ____

Member ID Number: ___________________________ Group ID Number: ____________________________

Who's financially responsible for payment of services? ____

Home Address & Phone: (if different from above)____

→→→→→→***Please Fill Out Back of Page***←←←←←←

For Office Use ONLY – TO BE COMPLETED BY INTAKE THERAPIST
Date of Intake:_______________ Diag. _________ Dept. ________ Therapist: _____________________________

PLEASE PRINT

PLEASE LIST CHILD(REN) AND SCHOOL(S):

Child	Grade	School Tel.#	Teacher	Guidance Counselor

Child(ren)'s Physician Information:

Name	Address	Phone

Are there/have there been medical problems with any family member? Yes____ No ____

If yes, please describe: ____

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Are there/have there been psychiatric problems with any family member? Yes____ No ____

If yes, please describe: ____

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Are there/have there been drug or alcohol problems with any family member? Yes____ No ____

If yes, please describe: ____

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Is anyone in your family currently taking prescription medication? Yes____ No ____

If yes, who, and what medications: ____

____

Developmental History – Please answer Yes or No	Yes	No
I. AT ANY AGE:		
Family Stresses: (Separation, divorce, relocation, financial)		
Concerns about peer relationships?		
Physical/sexual abuse?		
Problems with controls? Fears?		
Problems keeping immunizations current?		
II. PRE-NATAL/PREGNANCY/POST-NATAL:		
Adopted or foster child?		
Medical/delivery complications?		
Medications?		
Drug or alcohol use during pregnancy?		
III. PRESCHOOL DEVELOPMENT		
Any difficulties in achieving motor milestones?		
Speech or language delays?		
Neurological problems?		

Body care difficulties? (Toileting, grooming)		
IV. SCHOOL AGE (5 THROUGH 18 YEARS)	Yes	No
Learning difficulties?		
Behavioral difficulties?		
Child Study Team evaluation? When? ____________		
Supplemental services? (Resource room, gifted and talented)		
Delayed physical maturation?		
Difficulties in academic achievement?		
Drug or alcohol use?		
Depression or suicidal behaviors?		
Assaultive behaviors?		

Has your child had any previous treatment services? If so, with who and for how long?

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Please let us know how you learned about West Bergen.

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To help us have a more complete picture of your child, please comment on his/her strengths and talents.

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