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West Bergen Mental Healthcare
Where Health Comes to Mind

West Bergen Mental Healthcare, Inc.
Application for Treatment Services - Child

Date: **Name**

Date of Birth **Social Security #**

Address **City/State/Zip**

Home Phone **Cell Phone** **Business Phone**

Email **Client's Biological Sex** ☐ Male ☐ Female ☐ Intersex/DSD

Client's Education Level ☐ Elementary ☐ Junior High ☐ High School ☐ Associate's ☐ Bachelor's ☐ Master's ☐ Doctorate ☐ Vocational ☐ GED/High School Equivalency ☐ Some College ☐ Did not complete

Client's Marital Status ☐ Never Married/Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Client's Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Client's Race ☐ Native Hawaiian/Pacific Islander ☐ African American ☐ American Indian/Alaskan ☐ Asian ☐ Other ☐ White ☐ Identified by Two or More

Smoking Status: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Parent/Guardian #1 (If Applicable) Social Security # DOB

Address & Phone (If different from above)

Parent/Guardian #2 (If Applicable) Social Security # DOB

Address & Phone (If different from above)

Parents/Guardian Marital Status

Please list every member of your household:

Name Date of Birth Sex Ethnicity Relationship

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Name Date of Birth Sex Ethnicity Relationship

Insurance Information

Policy Holder's Name

Insurance Co. Member ID # Group ID #

Who is financially responsible for payment of services?

Address and Phone (if different from above)

PLEASE LIST CHILDREN AND SCHOOLS

Child	Grade	School	School Tel.#	Teacher	Guidance Counselor

Who is your primary care physician?

Name and Address

Are there/have there been medical problems with any family member? ☐ Yes ☐ No

if yes, please describe

Are there/have there been psychiatric problems with any family member? ☐ Yes ☐ No

if yes, please describe

Are there/have there been drug or alcohol problems with any family member? ☐ Yes ☐ No

if yes, please describe

Is anyone in your family currently taking prescription medication?

if yes, by who and what medications?

DEVELOPMENTAL HISTORY - PLEASE CHECK YES OR NO

i. AT ANY AGE:

Family Stresses: (separation, divorce, relocation, financial)	☐ Yes	☐ No
Concerns about peer relationships?	☐ Yes	☐ No
Physical/sexual abuse?	☐ Yes	☐ No
Problems with controls? Fears?	☐ Yes	☐ No
Problems keeping immunizations current?	☐ Yes	☐ No

II. PRE-NATAL/PREGNANCY/POST-NATAL

Adopted or foster child?	☐ Yes	☐ No
Medical/delivery complications?	☐ Yes	☐ No
Medications?	☐ Yes	☐ No
Drug or alcohol use during pregnancy?	☐ Yes	☐ No

III. PRESCHOOL DEVELOPMENT

Difficulties in achieving motor milestones?	☐ Yes	☐ No
Speech or language delays?	☐ Yes	☐ No
Neurological problems?	☐ Yes	☐ No
Body care difficulties? (toileting/grooming)	☐ Yes	☐ No

IV. SCHOOL AGE (5 THROUGH 18

Learning difficulties?	☐ Yes	☐ No
Behavioral difficulties?	☐ Yes	☐ No
Child Study Team evaluation?	☐ Yes	☐ No
if yes, when?		
Supplemental services? (resource room, gifted and talented)	☐ Yes	☐ No
Delayed physical maturation?	☐ Yes	☐ No
Difficulties in academic achievement?	☐ Yes	☐ No
Drug or alcohol use?	☐ Yes	☐ No
Depression or suicidal behaviors?	☐ Yes	☐ No
Assaultive behaviors?	☐ Yes	☐ No

Has your child had any previous treatment services?

If so, with who and for how long?

How did you hear about West Bergen?

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

Please read and sign below:

I agree that I have completed this form to the best of my ability and any information not included was done so intentionally.

I take full responsibility for disclosing the appropriate insurance information to West Bergen.

Signature: Date: