Child: ❒Male ❒Female DOB: _____ Age: _____ SSN # (required) _____

- ***SSN# <u>required</u> for all US Citizens.*** ****Non-citizens are <u>not</u> reported to immigration authorities.***

Form completed by: _____ Relation to child: _____

Today's Date: _____ Time: _____ Location: _____

Child's Legal Name (First, Middle, Last): _____ Preferred Name:_____

Street Address: _____ City: _____ Zip: _____

Home Phone: (_____)_____ Work/Cell (guardian): _____

Email address for guardian _____

<u>FAMILY</u>

Father's Name: _____ DOB: _____ Employer: _____

Address (if different from child): _____

Mother's Name: _____ DOB: _____ Employer: _____

Address (if different from child): _____

Parents Marital Status: _____ With whom does the child live? ☐ Birth Parents ☐ Adoptive Parents

☐ Foster Parents ☐ One parent _____ ☐ Other _____

Who has Legal custody of this child? _____

****If child lives with anyone other than birth parents or parents are divorced, documentation of legal custody is required prior to or at the time of intake.***

List all other persons living in the home, their age, and relationship to client:

_____

_____

_____

<u>EMERGENCY CONTACT</u>

Name: _____ Relationship: _____ Telephone: (_____)_____

Street Address:_____ City: _____ Zip: _____

<u>MEDICAL BENEFITS</u>

Medicaid #:_____ Insurance:❒ Yes ❒ No If yes, Provider:_____
Copy of card and signed Release of Information for Insurance and/or Medicaid required.

Primary care doctor/clinic name: _____ Phone: _____

Street Address:_____ City: _____ Zip: _____

List current physical health concerns: _____

List all current Medications: (list medication name, dose, reason for taking) Include Physical Health and Mental Health medications.

_____

_____

_____

INCOME

Annual Household Gross Income: $_____ **# in Household:** _____

MARITAL STATUS: (of the child)

❒ Never Married ❒ Married ❒ Divorced ❒ Living as Married

RACE

❒White ❒Asian ❒American Indian ❒Native Hawaiian/Other Pacific Islander ❒Black/African American

ETHNICITY Hispanic/Latino Yes ❒ No ❒

HOUSING

Current Residence:

❒Private Residence ❒On the Street ❒ Residential Care Home ❒Institutional Setting ❒ Community Shelter

❒ Supported Living ❒ Foster Care ❒ Group Home ❒ Specialized Community Group Home

Current Living Situation:

❒ Alone ❒ With Family/Relatives ❒ With Non-Related Persons

Are you currently homeless? ❒ Yes ❒ No If yes, how long have you been homeless? _____

Have you been homeless at any time during the past 3 years? ❒ Yes ❒ No If yes, how many times? _____

EDUCATION (Please list schools attended)

Grade	School	Special Classes?	Comments on Behavior/Adjustment

Highest Grade Completed: _____ Additional school support (IEP, special education, etc.) _____

OTHER

Number of times per day Tobacco used: _____ Disabilities: _____

Preferred language: _____ Other Languages Spoken: _____

Reason for Seeking Services: _____

_____

_____

_____

_____

Who referred the child to Red Rock? _____

Was the child ordered to treatment through the court or juvenile justice system? ☐Yes ☐No
If yes, what is the county in which the legal proceedings took place? _____
Name of probation officer: _____ Phone: _____

Is your child currently having thoughts of harming self and/or others? ☐Yes ☐No

If yes, describe: _____ _____

Is DHS or OJA currently involved with your child? ☐Yes ☐No

If yes, workers name: _____ Phone: _____

During the past year has your child…	**How often does this occur?**					**Is this a problem now?**
	Never	**Seldom**	**Sometimes**	**Often**	**Always**	
Experimented with alcohol and/or other drugs?	1	2	3	4	5	☐Yes ☐No
Experienced problems caused by drinking and/or using other drugs and kept using?	1	2	3	4	5	☐Yes ☐No
Drank alcohol and/or used drugs to alter the way that he/she feels?	1	2	3	4	5	☐Yes ☐No
Has he/she ever used intravenous (needle injected) drugs?	1	2	3	4	5	☐Yes ☐No

If you child is currently using drugs or alcohol, complete the information below:

Type of drug	Amount of use/how much:	Frequency of use/how often:	Date of last use:

Treatment History:

Has your child ever been treated for mental health and/or substance abuse problems? ☐Yes ☐No
If yes, list name of hospital/facility, date & reason for treatment: _____

_____

Previous services at this agency? ☐Yes ☐No If yes, when/where? _____

I consent for my child to receive treatment at Red Rock Behavioral Health Services (RR). I authorize RR to use/disclose any health information to obtain payment for the services received. I understand a bill may be sent to me and/or a third-party payor. I assign all insurance benefits to which I am entitled to Red Rock Behavioral Health Services. This agreement will remain in effect until revoked by me in writing or when all third party claims are satisfied. **I understand that I am financially responsible for all charges**. I have read this information and understand it.

Parent/Guardian: _____ Date: _____