

Red Rock Behavioral Health Services/Child Request for Services

Child:  Male  Female DOB: \_\_\_\_\_ Age: \_\_\_\_\_ SSN # (required) \_\_\_\_\_

- **SSN# required for all US Citizens. \*Non-citizens are not 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 \_\_\_\_\_

**FAMILY**

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**MEDICAL BENEFITS**

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: \_\_\_\_\_

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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? \_\_\_\_\_

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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? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Never 1	Seldom 2	Sometimes 3	Often 4	Always 5	
Experimented with alcohol and/or other drugs?	1	2	3	4	5	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experienced problems caused by drinking and/or using other drugs and kept using?	1	2	3	4	5	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drank alcohol and/or used drugs to alter the way that he/she feels?	1	2	3	4	5	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has he/she ever used intravenous (needle injected) drugs?	1	2	3	4	5	<input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_