Behavioral Care Center of New Jersey, LLC
205 Ridgedale Avenue, Suite 101
Florham Park, NJ 07932
Phone: (973) 660-0700

Patient Information:

Child's Name: _____

Mother's Name:_____ Father's Name:_____

Date of Birth: _____ Age: _____ Sex: M_____ F_____

Address : _____

_____

Phone: Home _____

Cell _____

Child's cell _____

Name of person who referred you: _____

Phone Number: _____

School Information:

School:_____
grade:_____

If your child receives special education services please specify:

_____
_____
_____

Has your child ever skipped or repeated a grade? If so when?

_____

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Has your child ever been diagnosed with a learning disability?

_____

Family Information:

Please list all people who currently live with the child:

Name	Relationship to child	Age

Mother's Occupation: _____
Father's Occupation: _____

Child's parents are:
married/domestic partners____ divorced____ separated____ never married____

If divorced or separated who has legal custody? _____

Has your child ever experienced the death of or separation from family members or close friends?

_____
_____
_____

Has your children ever experienced a traumatic or significantly upsetting event?

_____
_____
_____

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Have any family members suffered from any of the following psychiatric problems? If yes, who? Was treatment sought?

Anxiety:	_____	Aggression:	_____
Depression:	_____	OCD:	_____
Bipolar Disorder:	_____	Substance Use	_____
Panic Attacks:	_____	Other:	_____

Developmental Information:

Were there any complications during pregnancy or delivery? Y N
If yes please explain:
_____
_____

At what age did your child achieve the following developmental milestones?

Talking: _____ Crawling: _____
Walking: _____ Toilet Training: _____

Does your child now or has he or she ever had sleep problems? Y N
If so please explain:
_____
_____

Does your child have any medical problems or has he or she ever been in the hospital?
Y N If so please explain:
_____
_____

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Please list any current medications that your child is taking:

_____
_____

Has your child ever received mental health treatment? Y N
If so please explain when the treatment occurred, the reason for the treatment, and what type of treatment was received (i.e. individual therapy, family therapy, group therapy, hospitalization):

_____
_____

Is your child currently, or has he or she ever been prescribed psychotropic medication? Y N . If so please list all medications, doses, and when they were taken:

_____
_____
_____

Please describe why you are seeking treatment for your child/adolescent:

_____
_____
_____
_____
_____

When did these difficulties begin? Did any specific event occur prior to the onset of symptoms?

_____
_____
_____
_____
_____

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Please check off any of the following problems with which your child is currently struggling:

_____ sad/depressed mood
_____ anxious
_____ Panic Attacks
_____ Angry Outbursts
_____ Withdrawn
_____ Fatigue
_____ Decreased appetite
_____Increased appetite
_____ Excessive weight gain/loss

_____ Increased sleep
_____ Decreased sleep
_____ Nightmares
_____ Drug Use
_____ Poor attention
_____ hyperactivity
_____ Stealing
_____ Alcohol use
_____ Difficulty sleeping through the night

_____ Purging
_____Physical Aggression
_____ Truancy
_____ Suicidal thoughts
_____ Suicide attempt
_____ Self injury (i.e. cutting)
_____ Poor family relationships
_____ Poor peer relationships
_____ inappropriate sexual behavior