Psychology & Behavioral Health
New Patient Intake Packet
Dear Parent or Guardian,

Thank you for choosing Children’s National for your child’s care. Per your request, I am sending you new patient Intake Forms. We have a variety of general and specialized psychology services available in our department. We are an academically driven program that incorporates trainees at every level of clinical services.

We have a detailed intake process that is designed to improve efficiency and provide best service possible. In order to set up an appointment and receive an appropriate evaluation for your child, we ask that you carefully fill out all of the enclosed forms as completely as possible and return them via email, fax or US mail to the address provided below. Once we receive your packet, our team will review the information for the appropriate clinician and appointment. You will be contacted by one of our team members as soon as an appointment date becomes available.

Enclosed are the following:

1. Demographic Sheet
2. Child history Questionnaire

Please include a copy of the front and back of your child’s insurance card.

Methods for returning your packet are as follows:

**Mail:** Children’s National Health System
Division of Behavioral Science
111 Michigan Avenue NW, West Wing Floor P1
Washington, D.C. 20010

**Fax:** 202-476-5537

**Email:** kfuentes@childrensnational.org

We can be contacted at:
Main Number: 202-476-5980, option 2
Intake/New Patient: 202-476-8457

Thank you for choosing Children’s National Health System for your child’s care.
INFORMATION ALL PARENTS SHOULD KNOW ABOUT
MENTAL HEALTH INSURANCE COVERAGE

Children’s National Health System Outpatient Psychology provides in network services for a wide variety of insurance providers. We also provide documentation of billing and services if you prefer out of network coverage.

Please note that mental health coverage is frequently very different from medical coverage. Also, benefits allowed by your insurance provider are frequently subject to change beyond our control. We strongly encourage you to contact your insurance provider or benefits administrator to verify the specific mental health services allowed by your insurance plan.

 Verification of mental health benefits and preauthorization for services: As a courtesy to you, we obtain information regarding your mental health benefits and preauthorization before your first visit. You will be provided with the information we are given by your health plan and we encourage you to refer to your policy manual or call your plan to confirm the information provided to us.

 Co-payments: Costs are often a percentage of the charges incurred instead of a fixed dollar amount. Information about co-payments for mental health services is rarely listed on the insurance card and is obtained by calling the plan.

 Deductibles: Mental health services are often separate and in addition to the medical deductible outlined by your insurance plan. If the deductible required by your plan has not been reached, we may need to collect the full amount for services at the time of your appointment.

 Referrals: If your child is covered by a managed care insurance plan which requires referrals, you must obtain referral forms from your child’s primary care physician prior to your visit. Please note that a written referral is a requirement of the insurance company and that we must adhere to the plan’s administrative requirements in order to receive payment on your behalf.

 Limits: Frequently, mental health benefits are limited per calendar or plan year. Please consult your policy manual regarding your maximum calendar year or plan year benefits.

 Testing: Neuropsychological, psychological, and developmental testing benefits are always verified by our staff. Most insurance companies limit the number of testing hours covered. If your child requires testing beyond the number of hours authorized, you have the option of paying for the additional hours required for testing.
Demographic Sheet

<table>
<thead>
<tr>
<th>Patient's Name:</th>
<th>Patient Date of Birth:</th>
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<tbody>
<tr>
<td>Address:</td>
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<tr>
<td>Sex:</td>
<td>Cell Number:</td>
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<tr>
<td>Home Telephone:</td>
<td>Race:</td>
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<td>Email Address:</td>
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</tbody>
</table>

**Reason for Seeking Mental Health Services** (check all that apply)

- □ Behavior Problems
- □ Attention Deficit/Hyperactivity Disorder
- □ Depression
- □ Anxiety
- □ Autism
- □ Psychological/Educational Testing
- □ Developmental Evaluation
- □ Custody/Court/Legal
- □ Suicidal Ideation
- □ Other

**Who Referred You to CNMC Department of Psychiatry/Psychology?**

- □ CNMC Pediatrician ____________________________
- □ Non-CNMC Pediatrician __________________________
- □ Specialist (indicate specialty) ___________________
- □ School
- □ Emergency Department
- □ Other (specify) ____________________________
- □ General Hospital Discharge
- □ Psychiatric Hospital Discharge
- □ Social Worker/Counselor
- □ Psychiatrist
- □ Self-referred
- □ Other

**Insurance Information** (no information will be treated as self-pay)

- Primary Insurance Company: Secondary Insurance Company:
- Policy/Identification Number: Policy/Identification Number:
- Group Name/Number: Group Name/Number:
- Insurance Telephone Number: Insurance Telephone Number:
- Subscriber's/Policy Holder's Name: Subscriber's/Policy Holder's Name:

**Financially Responsible Parties (Guarantors)**

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<thead>
<tr>
<th>Primary Guarantor's Name:</th>
<th>Secondary Guarantor's Name:</th>
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<tbody>
<tr>
<td>Relationship to Patient:</td>
<td>Relationship to Patient:</td>
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<tr>
<td>Address (if different from patient):</td>
<td>Address (if different from patient):</td>
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<tr>
<td>Employer:</td>
<td>Employer:</td>
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<tr>
<td>Address:</td>
<td>Address:</td>
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<td>Home#</td>
<td>Home#</td>
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<td>Cell#</td>
<td>Cell#</td>
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<td>Work#</td>
<td>Work#</td>
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<tr>
<td>Email:</td>
<td>Email:</td>
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<tr>
<td>Social Security Number:</td>
<td>Social Security Number:</td>
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<tr>
<td>DOB:</td>
<td>DOB:</td>
</tr>
<tr>
<td>Marital Status:</td>
<td>Marital Status:</td>
</tr>
</tbody>
</table>

**Name of School the Child Attends and Address:**
Child’s History Questionnaire

Child’s Full Name: ____________________________________________________________

Child’s Date of Birth: _________________________________________________________

Name of the person completing this form: _________________________________________

Today’s date: __________________________________________________________________

Contact Information:

Parent’s full name: _____________________________________________________________
Address: _____________________________________________________________________
Phone: _____________________________________________________________________
Date of Birth/Age: _____________________________________________________________
Profession and/or work activity: __________________________________________________

Parent’s full name: _____________________________________________________________
Address: _____________________________________________________________________
Phone: _____________________________________________________________________
Date of Birth/Age: _____________________________________________________________
Profession and/or work activity: __________________________________________________

Other primary caregiver (Guardian/Significant Other/Other)
Caregiver’s full name: _________________________________________________________
Age: _____________________________________________________________________
Profession and/or work activity: __________________________________________________

Emergency Contact
Name: _____________________________________________________________________
Address: _____________________________________________________________________
Phone: _____________________________________________________________________
What are the main concerns that you have about your child? *(Required)*

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Child’s Race and Religion:
Race/Ethnicity: __________________________ Religion: __________________________
American Indian/ __________
Alaska Native __________ Protestant __________
Asian: Indian/Pakistani __________ Muslim __________
Asian: Chinese __________ Jewish __________
Asian: Other-specify __________ Hindu __________
Hispanic or Latino __________ Catholic __________
Black/African American __________ Buddhist __________
White/Caucasian __________ Other: Specify __________
Other: Specify __________ None __________

Is the child adopted? Yes______ No ______

Are there other children in the family? If yes please list
Name __________________________________________ Gender ______ Date of Birth ______ Age ______ Relation to child ______

________________________________________________________________________________

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Other persons living in the home (significant other, friend, grandparents, foster child, etc)
Name __________________________________________ Gender ______ Date of Birth ______ Age ______ Relation to child ______

________________________________________________________________________________

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Languages spoken in the home __________________________________________
List any Agencies or professionals currently providing services to your child and family.

<table>
<thead>
<tr>
<th>Agencies or professional</th>
<th>Age of child when services begun</th>
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Pregnancy History

During pregnancy with this child did the mother experience any of the following?

Medical Problems

No ____ Yes ____ If yes, how long _____________

Special diet

No ____ Yes ____ If yes, how long _____________

Medications

No ____ Yes ____ If yes, how long _____________

Length of pregnancy

Full-term (38-42 weeks) No ____ Yes ____

Number of weeks at birth

________________________________________________

Any accidents/injuries

No ____ Yes ____ If yes, describe__________________________

Birth History

Age of mother at birth of child

______________

Complications for mother during delivery

No _____ Yes _____

If yes, list _______________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Child’s birth weight

______________

Did the child need any of the following?

Was Oxygen Needed

No _____ Yes _____ if yes, why? ___________________________________________________________________

Special care

No _____ Yes _____ if yes, why? ___________________________________________________________________

How long did the child stay in the hospital after birth?

______________

How long did the mother stay in the hospital after birth?

______________

Describe your child in the first 6 months.

Easy baby

No ____ Yes _____

Enjoys people

No ____ Yes _____

Irritable

No ____ Yes _____

Difficult to sooth

No ____ Yes _____

Sleep/wake cycle poorly regulated

No ____ Yes _____

Unusually quiet

No ____ Yes _____

Unusually sick

No ____ Yes _____

Feeding difficulties

No ____ Yes _____

Strong reaction to light/sound/touch

No _____ Yes _____

Colic

No ____ Yes _____
Family History

Please list any medical or psychiatric illness in your family
____________________________________________________________________________________
____________________________________________________________________________________

Child’s Early Development (specify age)

Sat without support __________
Crawled __________
Walked without support __________
Used single words __________
(Other than mama or papa)
Used 2-3 word sentences __________
First began to sleep through the night __________
Daytime wetting stopped __________
Bed-wetting stopped __________
Bowel control __________

Child’s Medical History

Health Care Providers:
Child’s primary care physician: __________________________________________________________
Address: __________________________________________________________
Phone: __________________________________________________________

Date of last complete physical examination: __________________________________________

Does your child have any allergies (environmental, food, medication)? No ____ Yes ____
If yes, please list:
____________________________________________________________________________________
____________________________________________________________________________________

Does your child take any medications? No ____ Yes ____
(Include vitamins, over the counter drugs, and herbal medications)
Name __________________ Dosage __________________ Frequency __________________ Date began
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
Has your child ever been hospitalized for any reason?  
No _____ Yes _____

If yes, describe

<table>
<thead>
<tr>
<th>Reason</th>
<th>Date</th>
<th>Place</th>
<th>Length of stay</th>
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</table>

Does your child have a current or past history of? Any of the following:

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<thead>
<tr>
<th></th>
<th>No</th>
<th>Current</th>
<th>Past</th>
<th>List</th>
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</thead>
<tbody>
<tr>
<td>Head injury</td>
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<tr>
<td>Broken bones</td>
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<tr>
<td>Surgeries</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Birth defects</td>
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<tr>
<td>Poisoning (e.g.: lead)</td>
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<tr>
<td>Heart problems</td>
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<td>Kidney problems</td>
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<td>Liver disease</td>
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<td>Lung disease</td>
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<td>Blood disease</td>
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<td>Cancer</td>
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<td>Seizure</td>
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<td>Other neurological problems</td>
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<tr>
<td>(e.g.: headache)</td>
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<tr>
<td>Genetic disorder</td>
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<td>Hormonal problems (e.g.:</td>
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<td>diabetes, thyroid)</td>
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<td>Skin problems</td>
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<tr>
<td>Lyme disease</td>
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<tr>
<td>Impaired Sight</td>
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<tr>
<td>Impaired Hearing</td>
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<tr>
<td>Speech Difficulty</td>
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<tr>
<td>Sleeping Difficulty</td>
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<tr>
<td>Eating Disorder</td>
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<td>Sleep Apnea</td>
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<tr>
<td>Severe vomiting</td>
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<td>Choking events</td>
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<tr>
<td>Other problems</td>
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</table>
| Childhood diseases (child’s age in years)
| Chicken pox                   | No _____ Yes _____ Age __________ |
| German measles/Rubella        | No _____ Yes _____ Age __________ |
| Measles                       | No _____ Yes _____ Age __________ |
Scarlet Fever  No ____ Yes ____ Age __________
Whooping cough  No ____ Yes ____ Age __________
Strep throat  No ____ Yes ____ Age __________

Social Development

Does your child make friends easily:  No _____ Yes _____
Does your child have any difficulties interacting with other children?  No _____ Yes _____
Does your child have any difficulties interacting with adults?  No _____ Yes _____
Does your child have a “best friend?”  No _____ Yes _____

Preschool/School History

Is your child attending preschool/school? No _____ Yes _____
If yes, name of school __________________________________________
Child’s current school grade _______________________________________
Does your child attend any special classes or receive any special education services?  No _____ Yes _____ if yes, please name __________________________________________
Has your child ever repeated a grade in school or been “held-back” for any reason?  No _____ Yes _____ if yes, explain __________________________________________
Does your child have any learning or behavioral problems in school?  No _____ Yes _____ if yes, explain __________________________________________
__________________________________________________________________________________________
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__________________________________________________________________________________________
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Sleep Habits

What time does your child generally go to bed?  _____________ pm/am
What time does your child generally wake up?  _____________ pm/am
On average, how many hours does your child sleep per night?  _____________ hours
Does your child snore or seem to gasp for air during the night?  No _____ Yes _____

Stressors

Is your child facing significant stressors at this time? No _____ Yes _____
If yes, please describe
__________________________________________________________________________________________
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Is your family facing any significant stressors just now?
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Is there anything else you would like us to know that would assist us in understanding your child?
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