Dear Parent/Guardian:

Thank you for requesting an evaluation with Outpatient Psychiatry at Children’s National Medical Center. We have a wide variety of general and specialized psychiatric services available within our department. We are an academically driven program that incorporates trainees at every level of clinical services. We also have cutting edge research studies and clinical trials available if you request. We are very pleased to have the opportunity to serve you.

We have a detailed intake process that is designed to improve efficiency and provide the 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 in the envelope provided. We will not be able to process your request for an appointment unless the information is completed. Enclosed are the following:

1. Child’s History Questionnaire
2. Rating scales:
   a. Child Behavior Checklist
   b. SNAP scale
3. Release of Information Forms so we may contact your child’s pediatrician, school, or previous therapist
4. If possible, please include a copy of your child’s last physical exam and immunization record.

Please send the completed forms to:

Children’s National Medical Center
111 Michigan Ave., NW
Washington D.C. 20010

Attn: Outpatient Psychiatry Room 1200

After we receive your completed forms, the information will be carefully reviewed and we will contact you regarding appointment and clinician availability. We ask that you please be patient during this process as we have an extremely high demand for evaluation services. Although it is our goal to readily provide follow-up treatment whenever necessary, please note that follow-up treatment including specialized psychotherapy may not be available given the extremely high demand that we have for services. If this is the case, we will do our best to provide you referrals to other providers. Please be sure that we have a telephone number where you can be easily reached during the day, in case any questions emerge.

Important information regarding insurance coverage can be found on the following page. If you have any questions please feel free to contact us at 202-476-5544. Again, thank you for choosing Children’s National Medical Center.

Sincerely,

Intake Coordinator
INFORMATION ALL PARENTS SHOULD KNOW ABOUT
MENTAL HEALTH INSURANCE COVERAGE

Children’s National Medical Center Outpatient Psychiatry 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.

- **Please complete the information below:**
# INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Name of Primary Insurance:</th>
<th>Secondary Insurance:</th>
<th>Primary Guarantor’s Name:</th>
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<tr>
<th>Policy/Identification Number</th>
<th>Policy/Identification Number:</th>
<th>Relationship to Patient:</th>
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<tr>
<th>Group Name/Number:</th>
<th>Group Name/Number:</th>
<th>Address (if different from patient)</th>
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<tr>
<th>Insurance Telephone Number:</th>
<th>Insurance Telephone Number:</th>
<th>Employer:</th>
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<tr>
<th>Subscriber’s/Policy Holder’s Name:</th>
<th>Subscriber’s/Policy Holder’s Name:</th>
<th>Address:</th>
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<tr>
<th>Subscriber’s Date of Birth</th>
<th>Subscriber’s Date of Birth</th>
<th>Employer Telephone Number:</th>
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</table>
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 #’s _________________________________________________________
Age: ______________________________________________________________
Profession and/or work activity _______________________________________

Parent’s full name: ________________________________________________
Address: __________________________________________________________
Phone #’s _________________________________________________________
Age: ______________________________________________________________
Profession and/or work activity _______________________________________

Other primary caregiver (Guardian/Significant Other/Other)
Caregiver’s full name ______________________________________________
Phone #’s _________________________________________________________
Age: ______________________________________________________________
Profession and/or work activity _______________________________________

Emergency Contact (other than primary caregiver):
Name: ______________________________________________________________
Address: __________________________________________________________
Phone #’s _________________________________________________________
What are the main concerns that you have about your child?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Child’s Race and Religion:
Race/Ethnicity:                                             Religion
American Indian/                                   Protestant
Alaska Native                                               ______
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 ______

Other children in the family.
Name                  Gender  Date of Birth  Age  Relation to child
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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

Languages spoken in the
home

Children’s National Medical Center
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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</table>

**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:

- [ ] Oxygen
- [ ] 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 that runs 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

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)
<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Date began</th>
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</table>

Children’s National Medical Center
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:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Current</th>
<th>Past</th>
<th>List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury</td>
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<tr>
<td>Broken bones</td>
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<td></td>
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<tr>
<td>Surgeries</td>
<td></td>
<td></td>
<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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<tr>
<td>Kidney problems</td>
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<tr>
<td>Liver disease</td>
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<tr>
<td>Lung disease</td>
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<tr>
<td>Blood disease</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Seizure</td>
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<tr>
<td>Other neurological problems (e.g.: headache)</td>
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<tr>
<td>Genetic disorder</td>
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<tr>
<td>Hormonal problems (e.g.: diabetes, thyroid)</td>
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<tr>
<td>Skin problems</td>
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<tr>
<td>Lyme disease</td>
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<td></td>
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<tr>
<td>Impaired Sight</td>
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<td></td>
<td></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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<tr>
<td>Sleep Apnea</td>
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<tr>
<td>Severe vomiting</td>
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<tr>
<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)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Current</th>
<th>Past</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken pox</td>
<td>No _____</td>
<td>Yes</td>
<td>Age</td>
</tr>
<tr>
<td>German measles/Rubella</td>
<td>No _____</td>
<td>Yes</td>
<td>Age</td>
</tr>
<tr>
<td>Measles</td>
<td>No _____</td>
<td>Yes</td>
<td>Age</td>
</tr>
<tr>
<td>Scarlet Fever</td>
<td>No _____</td>
<td>Yes</td>
<td>Age</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>No _____</td>
<td>Yes</td>
<td>Age</td>
</tr>
<tr>
<td>Strep throat</td>
<td>No _____</td>
<td>Yes</td>
<td>Age</td>
</tr>
</tbody>
</table>
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 ____________________________________________________________

_______________________________________________________

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?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
Is there anything else you would like us to know that would assist us in understanding your child?
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
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____________________________________________________________________________