

PATIENT NAME	DATE OF BIRTH	MRN/CSN
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Referral information

Did you self-refer to Reid Behavioral Health? Yes No If No, who referred you to Reid Behavioral Health:

Name: _____ Profession: _____

Address: _____

Phone: _____

Who is your:

Primary Care Physician (PCP): _____ Phone Number: _____

Specialist (_____): _____ Phone Number: _____

Specialist (_____): _____ Phone Number: _____

Specialist (_____): _____ Phone Number: _____

Presenting Problem and Reason for Referral

Describe below all the difficulties, reasons, or concerns that you have about yourself and why you are seeking help at this time: _____

When was the problem first noted? By whom? _____

What kind of information or assistance are you currently hoping to attain? _____

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Behavioral Health Developmental History Questionnaire

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Are there work or school problems? Yes No If Yes, please describe: _____

Does this patient have any school learning and/or studying problems? Yes No If Yes, please describe:

Please describe any other problems or information that you think would be critical for us to know: _____

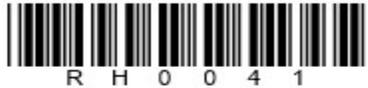
Please describe at least two or three of this person's strengths:

Please describe at least two or three of this person's weakness:

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Report and Intervention History

Has the patient been tested or assessed previously? Yes No If Yes, please complete the following:

Below, please list all past school, psychological, neuropsychological, psychiatric, educational, speech and language, or other types of evaluations administered. Indicate where, when, and by whom these evaluations were done, and whether you received a report about the evaluation. **Please attach copies of reports received.** It is essential that we receive copies of these reports to provide a truly comprehensive evaluation.

Evaluated At	Evaluated by	Date	Report Received
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Any comments about any of the evaluations listed above?

Below, please list all past or present interventions, treatments, related hospitalizations, or remediation services received. These include psychological, physical therapy, occupational therapy, nutritional therapy, speech and language therapy, and/ or other types of interventions. Indicate where, when, and by whom these were done and whether you have reports progress through the therapy or intervention. **Please attach copies of progress reports received.** It is essential that we receive copies of these reports to provide a truly comprehensive evaluation.

Received At	Evaluated by	Date	Report Received
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Any comments about any of the interventions and/or services listed above?

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Academic, Legal, And Medical History

School Information

Please list the schools attended and highest education achieved at that school:

_____	Grades: _____

Please tell us about any difficulties in school: _____

Legal History

Please note any relevant legal history:

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Medical History

Any problems with hearing? Yes No If Yes, please explain: _____

Any problems with vision? Yes No If Yes, please explain: _____

Any problems with allergies? Yes No If Yes, please explain: _____

List any serious illnesses, injuries, hospitalizations, and/or surgeries below:

Date: _____ Incident (Please Explain) _____

Did this patient ever have a high fever? Yes No If Yes, please explain: _____

Any history of any of the following neurological problems, disorders, or injuries?

- Dyslexia/LD Autism ADHD Fetal Alcohol Syndrome PTSD/Trauma Rad
- Sensory Integration Seizures Head Injury Stroke Lead Poisoning Headaches Tics
- Fainting Others Listed Below:

Has this child ever received any of the following?

Ct Scan: No Yes Date: _____ Results: _____

MRI: No Yes Date: _____ Results: _____

EEG: No Yes Date: _____ Results: _____

_____ No Yes Date: _____ Results: _____

_____ No Yes Date: _____ Results: _____

_____ No Yes Date: _____ Results: _____

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