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 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 Hospital
Division of Behavioral Health Services
6833 4th Street NW
Washington, DC 20012

Fax: (202) 715-5428

We can be reached via phone at:
(202) 729-3300

Thank you for choosing Children's National Hospital for your child's care.

INFORMATION ALL PARENTS SHOULD KNOW ABOUT
MENTAL HEALTH INSURANCE COVERAGE

Children's National Hospital 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.

Children's National

Demographic Sheet

PATIENT'S NAME:	PATIENT DATE OF BIRTH:
ADDRESS:	
SEX:	CELL NUMBER:
HOME TELEPHONE: RACE:	EMAIL ADDRESS:

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 CNH DEPTMENT OF PSYCHIATRY/PSYCHOLOGY?

- ☐ CNH Pediatrician: _____
- ☐ Non-CNH Pediatrician: _____
- ☐ Specialist (indicate specialty):
- ☐ School
- ☐ Emergency Department
- ☐ Other (specify):
- ☐ General Hospital Discharge
- ☐ Psychiatric Hospital Discharge
- ☐ Social Worker/Counselor
- ☐ Psychiatrist
- ☐ Self-referred

Have you seen a CNH Psychiatrist for medication management? ☐ No ☐ Yes Date: _____

Have you received Neuropsychological Evaluation at CNH? ☐ No ☐ Yes Date: _____

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)

Primary Guarantor's Name:	Secondary Guarantor's Name:
Relationship to Patient:	Relationship to Patient:
Address (if different from patient):	Address (if different from patient):
Employer:	Employer:
Address:	Address:
Home# Cell#	Home# Cell#
Work# Email:	Work# Email:
Social Security Number:	Social Security Number:
DOB: Marital Status:	DOB: Marital Status:

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 name:	
Age:	
Profession and/or work activity:	

Emergency Contact

Name :	
Address:	
Phone:	

What are the main concerns that you have about your child? **(Required: This helps us understand your worries and what you hope to receive from therapy services.)**

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? ☐No ☐Yes

Are there other children in the family? If yes please list

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: _____

List any Agencies or professionals currently providing services to your child and family.

Agencies or professional	Age of child when services begun

Pregnancy History

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

Medical problems ☐No ☐Yes
If yes, describe: _____
Special diet ☐No ☐Yes
If yes, describe: _____
Medications ☐No ☐Yes
If yes, list: _____
Full-Term (38-42 weeks) ☐No ☐Yes
If no, 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 (in days)? _____
How long did the mother stay in the hospital after birth (in days)? _____

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

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? (Include vitamins, over the counter drugs, herbal medications) ☐ No ☐ Yes

Name	Dosage	Frequency	Date began

Has your child ever been hospitalized for any reason (medical or psychiatric)? ☐ No ☐ Yes

Reason	Date	Place	Length of stay

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

	No	**Current**	**Past**	**List**
Head injury				
Broken bones				
Surgeries				
Birth defects				
Poisoning (e.g.: lead)				
Heart problems				
Kidney problems				
Liver disease				
Lung disease				
Blood disease				
Cancer				
Seizure				
Other neurological problems (e.g.: headache)				
Genetic disorder				
Hormonal problems (e.g.: diabetes, thyroid)				
Skin problems				
Lyme disease				
Impaired Sight				
Impaired Hearing				
Speech Difficulty				
Sleeping Difficulty				
Eating Disorder				
Sleep Apnea				
Severe vomiting				
Choking events				
Other problems				

Childhood diseases (child's age in years) ☐ No ☐ Yes Age: _____
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 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

Name of school: _____
Child's current school grade (or most recent completed): _____

Does your child attend any special classes or receive any special education services? ☐ No ☐ Yes
If yes, please explain: _____

Has your child ever repeated a grade in school or been "held-back" for any reason? ☐ No ☐ Yes
If yes, please explain: _____

Does your child have any learning or behavioral problems in school? ☐ No ☐ Yes
If yes, please explain: _____

Sleep Habits

What time does your child generally go to bed? _____ AM/PM
What time does your child generally wake up? _____ AM/PM
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:

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?