Fortis Behavioral Health
220 Wintergreen Dr., Suite B
Lumberton, NC 28358
910-536-1719
910-668-8048

Pediatric Psychiatric Intake Form

How did you hear about our practice?

- ☐ Referral from doctor
- ☐ Referral from a friend
- ☐ Google
- ☐ Social Media
- ☐ Advertisement
- ☐ Other

Patients Name:_____

Preferred Name:_____

Date of Birth:_____

Social Security Number:_____

Primary caregiver's name:_____

Primary caregiver's relationship to patient:_____

Primary caregiver's phone number:_____

Primary caregiver's E-mail:_____

Address:_____

City:_____

State:_____

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Zip code:_____

Primary language:_____

Hispanic or Latino? ☐ Yes ☐ No

Ethnicity:_____

Race:_____

Are there any cultural or religious practices I should be aware of when providing you care?

_____

_____

Is the child in school? ☐ Yes ☐ No

Is the child home schooled? ☐ Yes ☐ No

Family History

Marital status of parents:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

☐ Partnership ☐ Never married

Is the child adopted? ☐ Yes ☐ No

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If yes, does the child know? ☐ Yes ☐ No

Does your child have step-parents whom they live with full or part time? ☐ Yes ☐ No

Child lives with:_____

_____

EMERGENCY CONTACT #1

Name:_____

Relationship:_____

Phone number:_____

EMERGENCY CONTACT #2

Name:_____

Relationship:_____

Phone number:_____

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General Health

Current Height:_____

Current Weight:_____

What time of day is the child's demeanor/behavior best?_____

What time of day is the child's demeanor/behavior worst?_____

Is the child struggling in school or socially? ☐ Yes ☐ No

If yes, how?_____

PRESENTING CONCERN

CHIEF COMPLAINT: Please briefly describe the reason for seeking care for your child. If there are multiple reasons please list in order of importance.

_____

_____

Has your child seen any other providers for this reason? Yes ☐ No ☐

If yes, who and what was the outcome?_____

_____

Our practice focuses on non-crisis mental health care, and it's important for us to understand if you might need a level of care we do not provide.

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In order to ensure we connect your child with the best possible support, could you let us know if your child has ever engaged in self-harm or attempted suicide?

☐ Yes ☐ No

If yes please explain:_____

Please list all known drug allergies. If none please state "none":_____

_____

Please list all known food allergies. If none please state "none":_____

_____

Please list any other known allergies:_____

RXs: Please list all current prescription medications taken for MEDICAL OR MENTAL HEALTH. Please include: medication name, dose, approx start date, last dose change and prescribing clinician. Please obtain information from med bottles:

_____

_____

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OTC: Please list all over the counter (OTC) vitamins, herbs, or supplements you take regularly for MEDICAL OR MENTAL HEALTH. Please include: supplement name, dose, approx start date, and reason for taking:

_____

_____

HISTORICAL: Before your first appointment, please put together a list of all remembered MENTAL HEALTH medications that you've been prescribed in the past. Please include: medical name, dose, approx dates med was taken, reason for discontinuation, and prescribing clinician:

_____

_____

PREFERRED PHARMACY

Name:_____

Address:_____

Phone Number:_____

OUTSIDE PROVIDERS

Prior Psychiatric Provider

Name:_____

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Practice name:_____

Address:_____

Phone Number:_____

Dates under provider's care:_____

Reason for seeking new care:_____

_____

Current or most recent therapist or counselor

Name:_____

Practice name:_____

Address:_____

Phone Number:_____

Dates under provider's care:_____

If current, date starting with this clinician? Frequency of visits?: _____

_____

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If not current, approximate dates seen and reason for stopping services?_____

_____

Primary Care Practitioner (PCP)

Name:_____

Practice name:_____

Address:_____

Phone Number:_____

Last wellness checkup or physical exam:_____

Responsible Party

Who will be financially responsible for you?

☐ Myself ☐ Someone else

If you chose "someone else", please fill out the following.

Full Name:_____

Relationship to patient:_____

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Phone Number:_____

Method of Payment

What will be your method of payment?

☐ Insurance ☐ Self-pay ☐ Other:_____

If you chose "insurance" please fill out the following:

Primary Insurance Policy

Insurance Company:_____

Insurance Plan:_____

Policy #:_____

Group #:_____

If you are not the primary policy holder, please fill out the following.

Relationship to Primary Policy Holder:_____

Primary Policy Holder's Full name:_____

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Primary Policy Holder's Gender:_____

Primary Policy Holder's Date of Birth:_____

Primary Policy Holder's Social Security Number:_____

Primary Policy Holder's Address:_____

_____

Policy ID number:_____

If you are unable to provide insurance information, please provide a reason before continuing.

_____

Secondary Insurance Policy

Insurance Company:_____

Insurance Plan:_____

Policy #:_____

Group #:_____

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If you are not the primary policy holder, please fill out the following.

Relationship to Primary Policy Holder:_____

Primary Policy Holder's Full name:_____

Primary Policy Holder's Gender:_____

Primary Policy Holder's Date of Birth:_____

Primary Policy Holder's Social Security Number:_____

Primary Policy Holder's Address:_____

_____

Policy ID number:_____

If you are unable to provide insurance information, please provide a reason before continuing.

_____

I attest that all the information I have provided is true and complete to the best of my knowledge.

Signature:_____

Date:_____