1247 N. Cedar Crest Blvd. Suite 100
Allentown, PA 18103
Phone: 610-770-1800
Fax: 610-770-1805

Name of person completing this form: ____

Relation to the patient: ____

Date Completed: _______________

Identifying Information

Patient First Name:__________________Middle Name:___________Last Name: ____________________

DOB:__________________Age:________Social Security No.:__________________

Sex:______ male______female____transfeminine____transmasculine____other

Address:______________________________City:__________________State:______Zip Code:___________

Cell Phone:_______________________Home Phone:_________________Email: ______________________

Mother's Name:________________________DOB:__________________Cell Phone: __________________

☐ Biological Parent ☐ Step Parent ☐ Adoptive Parent ☐ Relative:______________________

Father's Name:_________________________DOB:__________________ Cell Phone: __________________

☐ Biological Parent ☐ Step Parent ☐ Adoptive Parent ☐ Relative: ______________________

Emergency Contact/Relation:____

Emergency Contact Phone:____________________________

Living Arrangements

Are biological parents: ☐ Married ☐ Never Married ☐ Divorced ☐ Separated

If divorced/separated/guardianship, please provide the office with a copy of custody/ guardianship records and describe here what are the custody arrangements (i.e. physical custody, medical decisions, etc.):

____

____

____

Number of moves in the patient's life: ______

Ever placed, boarded or lived away from family? ☐ Yes ☐ No

Explain: ____

List all the members of household (name/age) and indicate the relation to the patient:

____

What primary language is spoken in the home? ____

Does the patient speak the language? ☐ Yes ☐ No

Does the patient understand the language? ☐ Yes ☐ No

Who speaks the language in the home? ____

Which language does the patient prefer to speak? ____

How were you referred to CICS? ____

Reason for your visit:

____

____

____

____

Presenting problems (check all that apply):

☐ Temper Outbursts	☐ Short attention span	☐ Disobedient	☐ Head banging	☐ School trouble
☐ Withdrawn	☐ Distraction	☐ Infantile	☐ Rocking	☐ Bowel/bladder control
☐ Daydreaming	☐ Peer conflict	☐ Mean to others	☐ Shy	☐ Feeding/eating problems
☐ Fearful	☐ Phobic	☐ Destructive	☐ Strange behavior	☐ Sleeping problems
☐ Clumsy	☐ Impulsive	☐ Bed wetting	☐ Stealing	☐ Drugs/alcohol
☐ Overactive	☐ Stubborn	☐ Self-mutilating	☐ Lying	☐ Sickly
☐ Irritable	☐ Mood Swings	☐ Aggressive	☐ Anxiety	☐ Depressed
☐ Suicidal Statements	☐ Homicidal Statements	☐ Obsession with Technology		

Others (explain):

____

____

____

____

Medical & Mental Health History

Primary Care Physician:__________________________Phone:________________Fax:_____________

Primary Care Physician Address: ____

Pharmacy:_______________________________Phone:_____________________Fax:________________

Pharmacy Address: ____

Current or past medical history – list any diagnoses, surgeries or hospitalizations:

____

____

If hospitalized in the past, please explain where, when and why?

____

____

Has the patient received any previous services for mental health, occupational therapy or speech therapy?

☐ Yes ☐ No

If yes, please list location and date range services were performed: ____________________

____

Has the patient ever had a concussion or head injury? ☐ Yes ☐ No

If yes, when? Please describe nature of injury: ____________________________________

____

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No If yes, please describe:

____

Did mother have any illness or complications before delivery? ☐ Yes ☐ No If yes, please explain:

____

Did the biological parents abuse alcohol or drugs during pregnancy? ☐ Yes ☐ No

Length of pregnancy:__________________Birth weight: _______________________

Has the patient ever taken, or is currently taking any medications? ☐ Yes ☐ No

If yes, please list all medications name, dose and frequency:

____

____

Does the patient have any allergies that you are aware of? ☐ Yes ☐ No

If yes, please describe: ____

Please describe any concerns with mobility____

Any concerns with eating, swallowing, or feeding? ☐ Yes ☐ No

If yes, please explain (e.g., picky): ____

Does the patient have any hearing difficulties? ☐ Yes ☐ No

Is there a family history of hearing difficulties? ☐ Yes ☐ No If yes, who? _____________

Does the patient have any vision difficulties? ☐ Yes ☐ No

Is there a family history of any vision difficulties? ☐ Yes ☐ No If yes, who? _____________

Developmental History

As far as you know, did the patient meet development milestones at an appropriate age (rolling, sitting up, babbling and eating)?

☐ Yes ☐ No If no, please explain: ____

Educational History

Is patient currently enrolled in school? ☐ Yes ☐ No

School Name: ____

Grade: ________________

Types of Classes: ☐Regular ☐Gifted ☐IEP ☐EDB (emotionally disturbed behavior)

Other (please explain):_____________________________________

Does the patient receive special services at school? ☐ Yes ☐ No If so, please indicate:

- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Counseling Therapy
- ☐ Other: _________________________

Social History

Does the patient participate in any extracurricular activities or hobbies? ☐ Yes☐ No

Please describe: ____

In school, how many friends does the patient have? _________________________________

Please ask the patient to list who they see as important in their life:

____

____

____

____

____

____.

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Children's Integrated Center for Success

Patient Behaviors

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EYBERG CHILD BEHAVIORAL INVENTORY

Child's Name:______________________ DOB:______________ Child's Age______

Rater's Name:______________________ Date of Rating: ______________________

Relationship to child: ____

Directions: Below is a series of phrases that describe a child's behavior. Please:
(1) Circle the number describing how often the behavior occurs with your child
(2) Circle either "yes" or "no" to indicate whether the behavior is currently a problem.

1-Never   2-Almost never   3-Seldom   4-Sometimes   5-Often   6-Almost Always   Is this a problem now? (Y/N)

1.	Dawdles in getting dressed	1	2	3	4	5	6	Yes	No
2.	Dawdles or lingers at mealtime	1	2	3	4	5	6	Yes	No
3.	Has poor table manners	1	2	3	4	5	6	Yes	No
4.	Refuses to eat food presented	1	2	3	4	5	6	Yes	No
5.	Refuses to do chores when asked	1	2	3	4	5	6	Yes	No
6.	Slow in getting ready for bed	1	2	3	4	5	6	Yes	No
7.	Refuses to go to bed on time	1	2	3	4	5	6	Yes	No
8.	Does not obey house rules on his/her own	1	2	3	4	5	6	Yes	No
9.	Refuses to obey until threatened with punishment	1	2	3	4	5	6	Yes	No
10.	Acts defiant when told to do something	1	2	3	4	5	6	Yes	No
11.	Argues with parents about rules	1	2	3	4	5	6	Yes	No
12.	Gets angry when told to do something	1	2	3	4	5	6	Yes	No
13.	Has temper tantrums	1	2	3	4	5	6	Yes	No
14.	Sasses adults	1	2	3	4	5	6	Yes	No
15.	Whines	1	2	3	4	5	6	Yes	No
16.	Cries easily	1	2	3	4	5	6	Yes	No
17.	Yells or screams	1	2	3	4	5	6	Yes	No
18.	Hits Parents	1	2	3	4	5	6	Yes	No
19.	Destroys toys	1	2	3	4	5	6	Yes	No
20.	Is careless with toys and other objects	1	2	3	4	5	6	Yes	No
21.	Steals	1	2	3	4	5	6	Yes	No
22.	Lies	1	2	3	4	5	6	Yes	No
23.	Teases or provokes other children	1	2	3	4	5	6	Yes	No
24.	Verbally fights with friends their age	1	2	3	4	5	6	Yes	No
25.	Verbally fights with brothers/sisters	1	2	3	4	5	6	Yes	No
26.	Physically fights with friends	1	2	3	4	5	6	Yes	No
27.	Physically fights with brothers/sisters	1	2	3	4	5	6	Yes	No
28.	Constantly seeks attention	1	2	3	4	5	6	Yes	No
29.	Interrupts	1	2	3	4	5	6	Yes	No
30.	Is easily distracted	1	2	3	4	5	6	Yes	No
31.	Has short attention span	1	2	3	4	5	6	Yes	No
32.	Fails to finish tasks or projects	1	2	3	4	5	6	Yes	No
33.	Has difficulty entertaining himself	1	2	3	4	5	6	Yes	No
34.	Has difficulty concentrating on one thing	1	2	3	4	5	6	Yes	No
35.	Is overactive or restless	1	2	3	4	5	6	Yes	No

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Dietary Habits

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Please fill out this sheet only if reporting picky or limited eating. Please check all foods eaten currently and consistently. If used to eat but no longer does, please indicate. Write in any other foods eaten.

MEAT	**VEGETABLE (please indicate cooked or raw)**
◯ beef/hamburger ◯ chicken ◯ chicken nuggets only ◯ ham ◯ hot dog ◯ bacon ◯ fish ◯ clam, crab, shrimp, lobster ◯ lunch meat ◯ pepperoni/salami ◯ eggs ◯ peanut butter ◯ pork / pork chops ◯ other:	◯ carrots ◯ corn or corn on the cob ◯ beans ◯ green beans ◯ peas ◯ broccoli ◯ cauliflower ◯ lettuce ◯ tomato ◯ peppers ◯ mushroom ◯ cucumber ◯ celery ◯ squash/ zucchini ◯ cabbage ◯ other:
DAIRY ◯ yogurt ◯ cheese ◯ cheese sticks ◯ milk ◯ cream cheese ◯ cottage cheese ◯ other: **DRINKS** ◯ water ◯ milk ◯ fruit juice ◯ soda ◯ other:	**FRUIT** ◯ cantaloupe or honeydew ◯ apple ◯ banana ◯ pineapple ◯ orange ◯ strawberry ◯ blueberry / raspberry/ black berry ◯ plum ◯ pear ◯ peach / nectarine ◯ grapes / raisins ◯ watermelon ◯ cherries ◯ other:
STARCH (please indicate how prepared) ◯ potatoes ◯ pasta with sauce ◯ pasta without sauce ◯ macaroni and cheese ◯ bread ◯ toast ◯ bagel / muffin ◯ donut ◯ pancake ◯ waffle ◯ cereal with milk ◯ cereal without milk ◯ pop tart ◯ granola bar ◯ rice ◯ crackers ◯ tortillas ◯ French fries ◯ other:	**SNACKS** ◯ candy ◯ cake ◯ ice cream ◯ pudding ◯ chips ◯ Doritos ◯ popcorn ◯ pretzels ◯ cheese puffs / cheese doodles ◯ goldfish ◯ nuts ◯ cookies ◯ gummy snacks / fruit snacks ◯ other: **OTHER** ◯ pizza ◯ soup ◯ condiments

Consent and Conditions to Treatment

Patient Name:____**DOB**: _____________________

Parent(s)/Legal Guardian(s) Name(s): ____

Please select: Mother Father Legal Guardian

Parent(s)/Legal Guardian(s) Name(s): ____

Please select: Mother Father Legal Guardian

We/I hereby voluntarily consent to the rendering of such care, including diagnostic procedures, medical treatment, and/or mental health treatment by providers of CICS as may be deemed necessary in their professional judgment. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my/ my child's condition.

We/I understand and grant permission to use de-identified data from all diagnostics and treatments for research towards improving future diagnostics and care recommendations.

We/I understand that CICS reserves the right to request random drug/ substance testing as deemed necessary and in the best professional judgement of treating providers. Failure to participate in requested testing, or a positive result to a requested test may result in termination from CICS services.

We/I acknowledge that we are (I am) financially responsible for all charges in connection with care and treatment rendered by CICS providers.

____

Printed Name of Parent/ Legal Guardian Signature Date

____

Printed Name of Parent/ Legal Guardian Signature Date

____

Printed Name of Patient (14 yrs+) Signature Date

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have read and fully understand the HIPAA Privacy Practices document from Children's Integrated Center for Success, which sets forth the ways in which my protected health information may be used or disclosed by Children's Integrated Center for Success and outlines my rights with respect to such information.

PATIENT RIGHTS, RESPONSIBILITIES, & POLICIES

I hereby acknowledge that I have read and fully understand the CICS Patient Rights/ Responsibilities and Policies document/informed consent and agree to the policies outlined in the document. I have been offered an opportunity to ask questions about policies at anytime.

FINANCIAL POLICY

I hereby acknowledge that I have received, read and fully understand the financial policy set forth by Children's Integrated Center for Success. I agree to the terms of this financial policy. I understand and agree that the terms of this financial policy may be amended by the practice at anytime without prior notification to patients. I authorize Children's Integrated Center for Success to release any of my of my child's information and/or records to all my insurance companies to substantiate claims and payments.

____

Printed Name of Client (14yrs+) Signature Date

____

Printed Name of Legal Guardian Signature Date

____

Printed Name of Party Responsible for Payment Signature Date
(if different than above)

Regarding the Adverse Childhood Experience Questionnaire, this is a screening tool that is now widely used by healthcare practitioners. ACEs are adverse childhood experiences that can be detrimental to a child's development and can be correlated with higher rates of negative physical and mental health outcomes.

If your child is under 14 years old please answer the questions for them as they apply to the child. If your child is between 14 and 18 years old answer the questions together with them. If your child is 18 years old or older have your child complete the questionnaire.

Adverse Childhood Experience (ACE) Questionnaire

Patient Name: ____

Today's Date: ___________________________

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often**…
   Swear at you, insult you, put you down or humiliate you?
   Or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes, enter "1" ___________

2. Did a parent or other adult in the household **often**…
   Push, grab, slap, or throw something at you?
   Or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes, enter "1" ___________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   Or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes, enter "1" ___________

4. Did you **often** feel that…
   No one in your family loved you or thought you were important or special?
   Or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes, enter "1" ___________

5. Did you **often** feel that…
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   Or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes, enter "1" ____________

6. Were your parents ever separated or divorced?
   Yes No If yes, enter "1" ____________

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   Or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   Or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes, enter "1" ____________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes, enter "1" ____________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes, enter "1" ____________

10. Did a household member go to prison?
   Yes No If yes, enter "1" ____________

Now add up your "Yes" answers:___________This is your ACE Score