



1247 S. 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):

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 Withdrawn | 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

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



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.

<p>MEAT</p> <ul style="list-style-type: none"> <input type="radio"/> beef/hamburger <input type="radio"/> chicken <input type="radio"/> chicken nuggets only <input type="radio"/> ham <input type="radio"/> hot dog <input type="radio"/> bacon <input type="radio"/> fish <input type="radio"/> clam, crab, shrimp, lobster <input type="radio"/> lunch meat <input type="radio"/> pepperoni/salami <input type="radio"/> eggs <input type="radio"/> peanut butter <input type="radio"/> pork / pork chops <input type="radio"/> other: 	<p>VEGETABLE (please indicate cooked or raw)</p> <ul style="list-style-type: none"> <input type="radio"/> carrots <input type="radio"/> corn or corn on the cob <input type="radio"/> beans <input type="radio"/> green beans <input type="radio"/> peas <input type="radio"/> broccoli <input type="radio"/> cauliflower <input type="radio"/> lettuce <input type="radio"/> tomato <input type="radio"/> peppers <input type="radio"/> mushroom <input type="radio"/> cucumber <input type="radio"/> celery <input type="radio"/> squash/ zucchini <input type="radio"/> cabbage <input type="radio"/> other:
<p>DAIRY</p> <ul style="list-style-type: none"> <input type="radio"/> yogurt <input type="radio"/> cheese <input type="radio"/> cheese sticks <input type="radio"/> milk <input type="radio"/> cream cheese <input type="radio"/> cottage cheese <input type="radio"/> other: <p>DRINKS</p> <ul style="list-style-type: none"> <input type="radio"/> water <input type="radio"/> milk <input type="radio"/> fruit juice <input type="radio"/> soda <input type="radio"/> other: 	<p>FRUIT</p> <ul style="list-style-type: none"> <input type="radio"/> cantaloupe or honeydew <input type="radio"/> apple <input type="radio"/> banana <input type="radio"/> pineapple <input type="radio"/> orange <input type="radio"/> strawberry <input type="radio"/> blueberry / raspberry/ black berry <input type="radio"/> plum <input type="radio"/> pear <input type="radio"/> peach / nectarine <input type="radio"/> grapes / raisins <input type="radio"/> watermelon <input type="radio"/> cherries <input type="radio"/> other:
<p>STARCH (please indicate how prepared)</p> <ul style="list-style-type: none"> <input type="radio"/> potatoes <input type="radio"/> pasta with sauce <input type="radio"/> pasta without sauce <input type="radio"/> macaroni and cheese <input type="radio"/> bread <input type="radio"/> toast <input type="radio"/> bagel / muffin <input type="radio"/> donut <input type="radio"/> pancake <input type="radio"/> waffle <input type="radio"/> cereal with milk <input type="radio"/> cereal without milk <input type="radio"/> pop tart <input type="radio"/> granola bar <input type="radio"/> rice <input type="radio"/> crackers <input type="radio"/> tortillas <input type="radio"/> French fries <input type="radio"/> other: 	<p>SNACKS</p> <ul style="list-style-type: none"> <input type="radio"/> candy <input type="radio"/> cake <input type="radio"/> ice cream <input type="radio"/> pudding <input type="radio"/> chips <input type="radio"/> Doritos <input type="radio"/> popcorn <input type="radio"/> pretzels <input type="radio"/> cheese puffs / cheese doodles <input type="radio"/> goldfish <input type="radio"/> nuts <input type="radio"/> cookies <input type="radio"/> gummy snacks / fruit snacks <input type="radio"/> other: <p>OTHER</p> <ul style="list-style-type: none"> <input type="radio"/> pizza <input type="radio"/> soup <input type="radio"/> 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
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Printed Name of Parent/ Legal Guardian	Signature	Date
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Printed Name of Patient (14 yrs+)	Signature	Date
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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
(if different than above)

Signature

Date



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



Children's Integrated Center for Success Every Child, Every Time

+

New Patient Registration (NPR)		
First Name:	Middle Name :	Last Name :
Date of Birth:		Gender:
Address:		
City:	State: PA	Zip Code:
Phone Number:	Email:	
Primary Concerns :		
Referred By:		
Primary Insurance Details		
Primary Insurance Name:		
Policy Number:	Group Number:	
Policy Holder Name:	Relationship with Patient:	
City:	State:	Zip Code:
Parent 1 Name :	Date of Birth:	
Parent 2 Name :	Date of Birth:	
Secondary Insurance Details		
Secondary Insurance Name:		
Policy Number :	Group Number	
Policy Holder Name :	Relationship with Patient:	
** OFFICE USE ONLY ** Verification Of Benefits		
Effective Date:	In or Out of Network:	
Co-Pay:	Co-Insurance:	
No. of Visits Allowed :	Authorization Number :	
Notes: _____		
Appointment Details		
Provider Name : CICS Group		
Appointment Date :		
Appointment Time:		
Initial Call Date :	2019	



Children's Integrated Center for Success Every Child, Every Time

CLINICAL SCREENING GUIDELINES FOR ADMISSION OF CLIENTS 12 YEARS AND YOUNGER

Name: _____ Age: _____

Any history of inpatient psychiatric hospitalizations?

- No
- Yes

Any history of suicidal thoughts, attempts or self-injurious behavior?

- No
- Yes

Any history of county involvement (i.e. Children and Youth Services)?

- No
- Yes

Is this appointment court mandated?

- No
- Yes

Any history of being on 3 or more psychotropic medications?

- No
- Yes

Notes: