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?** _____

**I am interested in**: *(please select from the following)*

| ☐ ***Gap Care.*** | ☐ ***Integrated Care.*** | ☐ ***I am not sure.*** |
|---|---|---|
| (already receiving services provided outside of CICS and you are looking to complete your existing circle of care) | ("one-stop shop" where all services will be provided by CICS. Using a team approach, we will give you a 360° understanding of your child) | |

**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| ☐ Withdrawn | ☐ Distraction | ☐ Infantile | ☐ Rocking | ☐ Bowel/bladder control |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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# 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**
- ◯ 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:

**VEGETABLE (please indicate cooked or raw)**
- ◯ 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

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# 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 |

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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: |

| 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 : 10/9/2018 |

# 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: