New Client Application

CLIENT INFORMATION

Child's Legal Name____Nickname________________________Sex____________
Date of Birth_____________________________Age: ____years____months SSN____
Primary Residence of Child____City/State_______________________Zip_____________
Home Phone Number____
Insurance Carrier____Phone_____________________________________
Member Name____Member ID__________________________________

PARENT/GUARDIAN INFORMATION

1st Guardian's Name____Home Phone_____________________________
Relationship_____________________Email Address____________________________________Cell Phone______________________
Address (if different from child) ____
Employer____Title_____________________________Work Phone_____________________

2nd Guardian's Name____Home Phone_____________________________
Relationship_____________________Email Address____________________________________Cell Phone______________________
Address (if different from child) ____
Employer____Title_____________________________Work Phone_____________________

Are there circumstances about the custody of your child that we should know about, which limit the sharing of records, picking up of your child, etc?____Yes____No (It is the parent's/guardian's responsibility to keep Ruby Beach Behavioral Pediatrics, LLC informed of changes in custody by providing current and complete legal documents each year and after any changes.)

ADDITIONAL AUTHORIZED CAREGIVERS AND EMERGENCY CONTACTS

Please list the name, relationship, and phone number for ALL individuals who will be directly involved in your child's treatment and/or responsible during home sessions (e.g., babysitter/nanny, grandparents, other caregivers). Basic treatment information and/or session feedback may be provided to these individuals unless otherwise specified. This list may also be used in the event there is illness/event warranting parent/guardian contact if the parents/guardians cannot be reached in a reasonable amount of time.

Name	Relationship	Phone Number	
			☐ Emergency Contact ONLY ☐ OK to provide feedback
			☐ Emergency Contact ONLY ☐ OK to provide feedback
			☐ Emergency Contact ONLY ☐ OK to provide feedback
			☐ Emergency Contact ONLY ☐ OK to provide feedback

Preferred Hospital (in case of emergency) ____
Address____Phone____

REFERRING INFORMATION/PRESENTING CONCERNS

Who referred you to Ruby Beach Behavioral Pediatrics, LLC? ____
Reason for Referral/Presenting Concerns:

MEDICAL INFORMATION HISTORY

Current Physician(s)/Health Care Provider(s):
Physician's Name______________________________Name of Practice/Clinic________________
Care Provided___________________________Phone_________________________________
Address ____

Physician's Name______________________________Name of Practice/Clinic________________
Care Provided___________________________Phone_________________________________
Address ____

Mental Health Provider Name_____________________Name of Practice/Clinic________________
Care Provided___________________________Phone_________________________________
Address ____

Mental Health Provider Name_____________________Name of Practice/Clinic________________
Care Provided___________________________Phone_________________________________
Address ____

List any assessments previously completed:

Medical History

Has your child had any injuries/surgeries/major illness in past 6 to 12 months (If yes, provide a description and date)

Does your child have a history of seizures? (If yes, specify name and dosage of any prescribed medication)

Does your child have an insect, drug or Latex allergy? (If yes, please describe)

Please specify any dietary needs:

❒ Vegetarian ❒ No milk/dairy ❒ Soy ❒ Casein ❒ Whey ❒ Other (List)

Does your child have any past or current diagnoses?

Diagnosis	Diagnosing Provider	When Diagnosed

*Please include a copy of any psychological evaluation and/or diagnostic reports

Is your child currently prescribed any medications to address behavioral/psychiatric concerns

Medication and Dosage	Prescribed for	Prescribed by

FAMILY/SOCIAL HISTORY

Please list all individuals in the home:

Name	Age	Relationship to Child	Time Spent with	Education Level	Known Diagnoses/ History of Behavioral Concerns?

Did/Does anyone in your family have a diagnosis or challenge similar to your child?_____Yes____No
If so, what is the individual's relation to your child? What are the similarities in diagnosis or challenge?

EDUCATIONAL HISTORY

School Name____Current Grade___________Current Teacher ___________________________
Phone______________________________________Contact Person (Name and Title) _ Address (Include County) _______________
____

Type of Class (seclusion, incision, blended, mainstream)______________________________Ratio ___________
Years Retained (if any)____Current Grades __________________________________
Current IEP:___Yes ___No

Describe any of the following opportunities or accommodations your child has in school.
Pull-Out/Resource Room or Specialized Small Group Instruction:

Opportunities for Mainstreaming:

Other Relevant Accommodations:

Services Provided by School	How Frequently	Session Length	Individual/Group?

Describe any concerns that you have or that have been reported to you specific to the school setting.

Do these concerns require immediate attention?

CURRENT SKILL LEVELS

Communication

- Please circle the main form of communication your child uses: gestures, words, sign language, augmentative communication device, other. If other is selected, please describe:
- Does your child have approximately 100 or more words they are able to use? ____Yes ____No
- Does your child talk about items that are not present? ____Yes ____No
- Please provide any other information you would like us to know about your child's communication:

Social Skills

- Does your child independently interact with peers? ____Yes ____No
- Describe your child's current strengths socially:
- Describe your child's current weaknesses socially:
- Please provide any other information you would like us to know about your child's social skills:

Self-Help Skills

- Is your child able to dress themselves without help? ____Yes ____No
- Is your child able to bathe or shower independently? ____Yes ____No
- Does your child have any issues with meal time or food variety? ____Yes ____No. If you answer yes, please briefly describe the issues:
- Please provide any other information you would like us to know about your child's self-help skills:

PROBLEM BEHAVIORS

Are there specific events that trigger problem behaviors? (Examples may be asking them to complete a task, telling them they cannot have a toy or activity, periods of low attention):

What do the behaviors typically look like? (Examples may include crying, laying on the floor, hitting, kicking, yelling, throwing items, head banging):

How long do the behaviors typically last?

ACKNOWLEDGEMENT

AS PARENT/GUARDIAN OF THE ABOVE, I VERIFY THAT THE INFORMATION PROVIDED IN THIS DOCUMENT IS CURRENT AND UNDERSTAND THAT I AM RESPONSIBLE FOR PROVIDING ANY UPDATES OR CHANGES TO THE INFORMATION TO RUBY BEACH BEHAVIORAL PEDIATRICS, LLC.

Signature of parent/guardian____Date________________________

Print name____