CENTER FOR PEDIATRIC BEHAVIORAL HEALTH

PATHWAYS PROGRAM INTAKE PACKET

Instructions:
Please complete and submit this screening form to schedule an appointment for an evaluation. You may submit this completed form to:

E-mail: info@centerforpbh.com
Fax: 910-660-8199
Mail: Center for Pediatric Behavioral Health
Pathways Program Intake
720 St. James Drive
Wilmington, NC 28403

A staff member will contact you to schedule an evaluation after you complete and submit the screening form.

You will need to provide the following additional information for the initial evaluation.
1.Your child's immunization records
2.Your child's most recent medical evaluation and medical records.
3.Records of therapy (previous and current) for your child's behavioral issues.

If you have any questions or need assistance, please call 910-660-8200 or email info@centerforpbh.com.

Client Information

Name: _____ Gender Assigned at Birth: _____

DOB: _____ Ethnicity/Race: _____

Current Diagnoses

_____

_____

If applicable: At what age did the client receive each diagnosis? _____

Who provided the diagnosis? _____

Current Medications

_____

_____

Caregiver/Legal Guardian Information

Name: _____ Legal Guardian? Yes

Address: _____

City, State, Zip: _____

Telephone: (Cell) _____ (Home)_____ (Work) _____

Email Address: _____

Who lives in the home? _____

_____

Physician Information

Name of Primary Care Physician: _____

Affiliation: _____

Address: _____

Telephone: _____

Schooling Information

Name of School: _____

Grade: _____

Teacher(s): _____

Address: _____

Telephone: _____

Does your child currently have an IEP? Yes ☐ No ☐

If yes, please provide a copy of it when submitting the intake packet.

Please rate your child's performance in relation to the following academic domains: (Check one)

Reading: Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐
Writing: Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐
Math: Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐
Physical Education: Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐
Computer/iPad Skills: Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

Medical and Family History

Medical History

Previous Illnesses: _____

Past surgeries/hospitalizations: _____

Most recent hearing screen: Date: _____; Results: _____

Most recent vision screen: Date: _____; Results: _____

Allergies (including food, please list adverse reactions): _____

Food intolerance? (e.g., lactose intolerance): _____

List any immunizations not up to date: _____

Age of puberty onset: _____

Age of first menstrual period: _____

If you listed any of the above medical symptoms/conditions, please provide the following:

Dates/Providers of previous treatment: _____

Current treating clinician: _____

Current therapeutic intervention/response: _____

Please list any other medical providers involved in your child's care (e.g., dentist, neurologist, gastroenterologist, gynecologist):

Provider Name: _____

Current treating clinician: _____

Current therapeutic intervention/response: _____

Family History

Is there a history of intellectual disability (ID) or developmental disability in your family? Y/N

If yes, please provide family member relationship and diagnosis:

_____

_____

If applicable, please list the family history of any medical or behavioral health information/treatment here:

_____

_____

_____

Social History

Are there any religious, spiritual, or cultural practices your family observes that may impact treatment?

Yes ☐ No ☐

If yes, please provide detail:

_____

Does your family or child have any relevant legal issues that may impact treatment?

Yes ☐ No ☐

If yes, please provide detail below:

_____

Do you currently utilize community resources (e.g., support groups, social services, Innovations Waiver, etc.)?

Yes ☐ No ☐

If yes, please list them here:

_____

Are there any meaningful activities that your child engages in with peers or the community (e.g., boy or girl scouts, sports teams, working, volunteering, clubs at school, etc.)?

Yes ☐ No ☐

If yes, please list them here:

_____

Previous Therapies

Please list all past and current therapies the client has received by completing each of the boxes below.

Service	Start/End Date (month/year)	Effect of Therapy	Therapist Information (Name, address, phone)
Occupational Therapy			
Physical Therapy			
Speech			
Early Intervention			
Behavioral Therapy (ABA)			
Psychiatry			
Mental Health Therapy			
Others: (please list)			

Adaptive Skills

What is the client's primary form of communication? (please check)
Gestures:☐ Picture Exchange:☐ Sign Language:☐ Vocal Language:☐ Other:☐ (describe)

Which one best describes your child's mental abilities? (please check)
Normal Intelligence☐ Mild Intellectual Disability☐ Moderate Intellectual Disability☐
Severe Intellectual Disability☐

What type of supervision does your child require? (Check one)
Can be left unattended for brief periods of time ☐
Needs continuous monitoring, but can be accomplished in a group ☐
Requires 1:1 supervision ☐

Please lists some tasks that your child does not often comply with completing:
Academic: _____
Self-Care: _____
Vocational/Household: _____

Please lists some tasks that your child complies with or enjoys completing:
Academic: _____
Self-Care: _____
Vocational/Household: _____

Does your child… (Select Yes or No)			
Feed Self	Yes ◯ No ◯	Make eye contact	Yes ◯ No ◯
Dress Self	Yes ◯ No ◯	Have a wide variety of leisure skills	Yes ◯ No ◯
Complete self-care tasks independently (e.g., brushing teeth, brushing hair)	Yes ◯ No ◯	Tolerate routine medical procedures (e.g., bloodwork, dental cleanings, physicals)	Yes ◯ No ◯
Toilet independently	Yes ◯ No ◯	Engage in after school activities/clubs	Yes ◯ No ◯
Shower/Bathe independently	Yes ◯ No ◯	Hold Employment/Volunteer	Yes ◯ No ◯
Tie shoes	Yes ◯ No ◯	Have money management skills	Yes ◯ No ◯
Ambulate independently	Yes ◯ No ◯	Understand relational boundaries (e.g., good vs bad touches; friendships vs romantic relationships)	Yes ◯ No ◯
Ask for things that they want or need?	Yes ◯ No ◯	Express when they are experiencing discomfort?	Yes ◯ No ◯
Stay near in public places (if appropriate)	Yes ◯ No ◯	Understand emergency vs nonemergency situations and who to contact for help	Yes ◯ No ◯
Talk to peers	Yes ◯ No ◯	Help with household chores	Yes ◯ No ◯
Imitate others	Yes ◯ No ◯	Complete schoolwork independently	Yes ◯ No ◯
Respond to various questions (who, what, when, where, why, etc.)	Yes ◯ No ◯	Label objects	Yes ◯ No ◯

OTHER BEHAVIOR PROBLEMS

Does your child have any other behaviors that you think are a problem? Check any one that describes your child's behavior.

Behavior	Occurs	Frequency
Tantruming	☐	times per☐hour☐day☐week☐month
Arguing	☐	times per☐hour☐day☐week☐month
Hurts self	☐	times per☐hour☐day☐week☐month
Hurts other people	☐	times per☐hour☐day☐week☐month
Complains of pain	☐	times per☐hour☐day☐week☐month
Throws or breaks things	☐	times per☐hour☐day☐week☐month
Makes inappropriate sounds	☐	times per☐hour☐day☐week☐month
Attention Deficits	☐	times per☐hour☐day☐week☐month
Phobias	☐	times per☐hour☐day☐week☐month
Overactive for age	☐	times per☐hour☐day☐week☐month
Separation Anxiety	☐	times per☐hour☐day☐week☐month

Doesn't pay attention	☐	times per ☐hour ☐day ☐week ☐month
Stereotypy (hand-flapping)	☐	times per ☐hour ☐day ☐week ☐month
Doesn't interact with people	☐	times per ☐hour ☐day ☐week ☐month
Public or Frequent Masturbation	☐	times per ☐hour ☐day ☐week ☐month
Inappropriate Social Boundaries	☐	times per ☐hour ☐day ☐week ☐month
Pica (eats inedible objects)	☐	times per ☐hour ☐day ☐week ☐month
Insists on routine	☐	times per ☐hour ☐day ☐week ☐month
Inflexible to change	☐	times per ☐hour ☐day ☐week ☐month
Other (list below)	☐	times per ☐hour ☐day ☐week ☐month

Presenting Problem

List the top three behavioral concerns:

1.

2.

3.

Goals for treatment:

_____
_____
_____

Goals for adulthood:

_____
_____
_____

Preferences

Please list some of your child's favorite things.

Activities: _____

Items: _____

Places to go: _____

People to interact with: _____

Other favorite things: ____