BIA
BEHAVIORAL INSTITUTE OF ATLANTA
5665 NEW NORTHSIDE DR., SUITE 500
ATLANTA, GA 30328
(404) 256-9325

CHILD & ADOLESCENT INTAKE QUESTIONNAIRE

Today's Date: _____ Person Completing Form: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Home Address: _____

_____

Child's cellphone (if different from parent's): _____

Child's email address (if different from parent's email): _____

Name of Parent/Guardian: _____

Nickname child calls this parent/guardian: _____

Address if different from child: _____

Email address: _____

Cellphone: _____ Alternate phone: _____

Name of Parent/Guardian: _____

Nickname child calls this parent/guardian: _____

Address if different from child: _____

Email address: _____

Cellphone: _____ Alternate phone: _____

Child's School: _____ Grade: _____ District: _____

Teacher(s): _____

Who referred you to our office? _____

Please sign if you give permission for us to thank this person: _____

CURRENT DIFFICULTIES AND STRENGTHS

Please describe the difficulties your child is now having and the type of services you are seeking.

_____

_____

_____

_____

_____

_____

Please indicate if your child is experiencing any of the following difficulties:

_____ School attention/concentration problems
_____ Grades dropping or consistently low
_____ Hyperactive, difficulty being still
_____ Impulsive, doesn't think before acting
_____ Sadness or Depression
_____ Generalized Anxiety (across many situations)
____ Specific fears/phobias (list): _____
____ Social Anxiety
_____ Obsessive-Compulsive / Rigid behavior patterns
_____ Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
_____ Isolated socially from peers
_____ Problems making or keeping friends
_____ Problems with eating
_____ Problems falling asleep
_____ Problems sleeping through the night (middle of the night or early morning waking)
_____ Trouble waking up
_____ Fatigue/tiredness during the day
_____ Nightmares
_____ Noncompliant, purposely does not obey (not due to language or cognitive deficits)
_____ Oppositional, defiant behavior
_____ Problems controlling temper
_____ Tantrums / "Meltdowns"
_____ Problems with authority (breaking rules or laws)
_____ Physically aggressive behavior towards others (biting, pinching, scratching, kicking, fighting)
_____ Verbally aggressive behavior towards others (name-calling, screaming, swearing, unkind comments)

_____ Self-injurious / Self-harm behavior (head banging, scratching, biting, cutting self)

_____ Wetting accidents (indicate day or night wetting): _____

_____ Soiling accidents or other bowel problems (withholding, refusal, fear/anxiety)

_____ History of trauma (specify): _____

_____ History of abuse (emotional, physical, sexual)

_____ Stress or difficulties related to gender identity

_____ Stress or difficulties related to sexuality, sexual interests, or behavior

_____ Alcohol or drug use/abuse

_____ Vocal or motor tics (e.g, grunts, squeals, eye blinks, throat clearing, grimacing, involuntary movements)

_____ Sensory problems (over-reacts or under-reacts to lights, sounds, tastes, textures, smells)

_____ Stress from conflict between parents

_____ Stress due to family financial problems

_____ Legal situation (anyone in family)

Other problems: _____

Describe your child's strengths, positive qualities, and any special abilities or skills.

_____

_____

_____

PARENTS / GUARDIANS AND FAMILY INFORMATION:

Child's parents are: Single Cohabitating Married Separated Divorced Widowed Other

If divorced, please provide a copy of the custody agreement/parenting plan.

Child lives with (one parent, both parents, other): _____

Has either parent been married before or since, and if so, list any children and their ages: _____

_____

If parents live apart, how much time does the child spend with each parent, siblings, step-siblings, etc.?

_____

_____

Does either parent's job require him/her to be away from home long hours or extended periods? If yes, explain:

_____

Who supervises the child's care when not in school? _____

Each parent/guardian may choose to complete these questions separately.

Parent/Guardian Name: _____ Age: _____

Biological Parent Adoptive Parent Step-parent Grandparent Guardian Other: _____

Occupation: _____ Education Completed: _____

Health: _____Excellent _____Good _____Fair _____Poor

Current relationship: Single Cohabitating Married Separated Divorced Widowed

If cohabiting or married, for how long? _____

If cohabitating or married, rate the quality of your relationship:

_____Great _____Very Good _____Good _____Fair _____Poor _____Very Poor

Overall level of stress: _____Very Low _____Low _____Average _____High _____Very High

What are the greatest sources of stress in parent's life?

_____

Rate parent's overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY): _____

Parent/Guardian Name: _____ Age: _____

Biological Parent Adoptive Parent Step-parent Grandparent Guardian Other: _____

Occupation: _____ Education Completed: _____

Health: _____Excellent _____Good _____Fair _____Poor

Current relationship: Single Cohabitating Married Separated Divorced Widowed

If cohabiting or married, for how long? _____

If cohabitating or married, rate the quality of your relationship:

_____Great _____Very Good _____Good _____Fair _____Poor _____Very Poor

Overall level of stress: _____Very Low _____Low _____Average _____High _____Very High

What are the greatest sources of stress in parent's life?

_____

Rate parent's overall level of happiness on a scale of 1-5 (1 = UNHAPPY, 5 = HAPPY): _____

Siblings: List IN ORDER OF AGE siblings of child/adolescent for whom you are seeking services.

Sibling Name	Age	School	Grade Placement	Grade Average	Conduct*

*(Please indicate good, fair, or poor conduct)

In general, how would you say the child for whom you are seeking services gets along with these siblings?

_____Great _____Very Good _____Good _____Fair _____Poor _____Very Poor

Describe: _____

_____

_____

_____

Others: List any other people who currently, or in the child's lifetime, have lived in your home (significant others, other family members, caregivers, nannies, etc.).

Name	Age	Relationship to Child	Years Living in Home

Are there other significant others, relatives, or caregivers who have a significant impact on how this child is raised?

_____

Please rate the overall level of FAMILY stress:

_____Very Low _____Low _____Average _____High _____Very High

What is the greatest source of stress for the family at this time?

_____

FAMILY HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who.

Yes	Condition	Family Member
_____	Alcohol / Substance Abuse	_____
_____	Attention-Deficit / Hyperactivity / Impulsivity	_____
_____	Autism Spectrum / Asperger's Disorder	_____
_____	Depression	_____
_____	Developmental Delays	_____
_____	Eating Disorder	_____
_____	Generalized Anxiety (across many situations)	_____
_____	Genetic Disorder (e.g., Down Syndrome, Fragile X)	_____
_____	Intellectual Disability	_____
_____	Learning Problems / Disabilities	_____
_____	Manic-Depression / Bipolar Disorder	_____
_____	Obsessive-Compulsive Disorder	_____
_____	Phobias	_____
_____	Posttraumatic Stress Disorder	_____
_____	Schizophrenia or other psychosis	_____
_____	Seizures or other neurological disorder	_____
_____	Sleep disorders	_____
_____	Social Anxiety	_____
_____	Speech or Communication Disorder	_____
_____	Suicide attempts / Suicide	_____
_____	Tic Disorder / Tourette's Disorder	_____
_____	Other: _____	

Is there a history in the immediate or extended family of any medical difficulties, illnesses or surgeries? Please list:

DEVELOPMENTAL HISTORY

Any difficulties during the pregnancy or delivery of this child? Please list any medications, periods of bed rest, etc.

Child was born: _____premature _____at full term _____late

Birth Weight _____ lbs, _____ oz

Difficulties following delivery? _____

Nursery (check all that apply): _____Well-baby _____Transitional ____Intensive Care _____Other

Describe your child's infant temperament (e.g., easy-going, sensitive, irritable, passive, difficult to soothe, etc.)

Any medical problems diagnosed in infancy? _____

As an infant, did this child seem: _____less active than average _____average _____overly active

As a toddler, did this child seem: _____ less active than average _____ average _____overly active

As a preschooler, did this child seem: _____ less active than average _____ average _____ overly active

As the child entered school, did this child seem: _____less active than average _____ average _____ overly active

Has your child had any previous developmental, psychological, psychiatric, or neurological examinations? If so, by whom, when, and what was your understanding of their findings?

(**Please provide copies of previous psychological reports**.)

At what age did your child accomplish these developmental tasks? If your child has not met one or more milestones, leave those items blank or write "not yet."

	Early	On-Time	Late	Approximate age (if known)
Speech and Language				
Coo/babble				
Respond to name				
Say first word				
Use gestures (wave, point)				
Put words together				
Speak in sentences				
Follow simple directions				
Follow multistep directions				
Motor Skills				
Roll over				
Sit alone				
Stand alone				
Walk alone				
Hold pencil correctly to mark				
Write legibly				
Self-Help/Independence				
Feed self				
Toilet train (bladder)				
Toilet train (bowel)				
Dress self				
Bathe self				
Social/Emotional				
Smile at others				
Laugh aloud				
Show affection				
Engage in pretend play				
First friendship				
Understand others' feelings				
Control feelings when upset				
Show responsibility				

MEDICAL HISTORY

Name of Child's Primary Physician: _____

Name of Physician's Practice (if applicable): _____

Physician's Phone and Email: _____

List any other physicians or health professionals your child sees for services on a regular basis.

_____

_____

_____

When was your child last seen by a physician? _____

Rate your child's overall health: _____Excellent _____Good _____Fair _____Poor

Child's current height: _____ft, _____in. Weight: ____lbs.

Does your child have any hearing or vision problems? _____

Date of last hearing test and who performed (physician, audiologist, school) _____

Date of last vision test and who performed (physician, optometrist, school) _____

Is your child: _____right handed _____left handed _____does not favor one hand

List any operations, serious illnesses, injuries (especially head), hospitalizations, allergies, ear infections, or other medical conditions your child has had.

_____

_____

_____

_____

_____

List any medications your child is currently taking, including over-the-counter drugs, vitamins, and other nutritional supplements (include dosages). Also list previous medications and dates if taken for an extended period of time.

_____

_____

_____

_____

_____

Describe your child's regular diet (i.e, favorite and least favorite foods). Do you have any concerns about your child's eating habits (e.g., aversion to certain tastes, textures, overly restricted eating, overeating, unhealthy eating)?

What is your child's typical bedtime and wake time each day? Any concerns about your child's sleeping habits?

EDUCATIONAL AND SOCIAL HISTORY

List in chronological order all schools your child has attended:

School	Dates Attended From _____ to _____	Grade Placement	Grade Average	Behavior/Conduct*

*(Please indicate good, fair, or poor conduct)

What concerns does your child's current teacher have?

Child's attitude toward school: _____

Favorite subject? _____ Least favorite subject? _____

Ever repeated or skipped a grade? If so, which? _____

Gifted or Accelerated Curriculum? Which years? _____

Tutoring? When, with whom, which subjects: _____

Has your child had a 504 plan _____ or IEP _____for special education? Current _____ Previous years _____

If your child has received/receives special education services, for which Georgia eligibility categories:

_____ Autism Spectrum Disorder
_____ Deafblind
_____ Deaf/Hard of Hearing
_____ Emotional and Behavioral Disorder
_____ Intellectual Disability (Circle one: MID, MoID, SID)
_____ Other Health Impairment (includes Attention-Deficit/Hyperactivity Disorder)
_____ Orthopedic Impairment
_____ Significant Developmental Delay
_____ Specific Learning Disability (Circle all that apply: Reading Math Written Language)
_____ Speech-Language Impairment
_____ Traumatic Brain Injury
_____ Visual Impairment and Blindness

Describe your child's special education services and/or any disability accommodations: _____

How does your child interact with peers and adults in social situations? Do you have concerns about your child's social skills or development?

List your child's activities:

Sports (list): _____

Music (list): _____

Clubs/Groups (list): _____

Dance (list): _____

Other: _____

BEHAVIOR MANAGEMENT / DISCIPLINE

Approximately what percentage of parenting is done by each parent? _____

Describe each parent's approach to discipline. (examples: redirect behavior, selectively ignore/ignore on purpose, let situation go/avoid conflict, time out, send to room, take away an activity or an item, assign additional chores, ground child, problem-solve/negotiate, reward system, raise voice/yell, threaten, physical punishment)

Which behavioral strategies seem to be most effective and least effective with your child? _____

Please list the five things you would like for your child to do more of and less of in order of priority to you. For example, instead of saying, "I want my child to be more responsible," translate that into actual behaviors such as do household chores, care for brothers and sisters, etc.

Would like Child to do More Often	Would like Child to do Less Often
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

LEGAL HISTORY

Have you every filed or been involved in any litigation? Please explain: _____

Is there anything else we should know about your child that was not covered by this form?

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NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

Welcome to the Behavioral Institute of Atlanta (BIA). This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your clinician about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY

Communication between you and your clinician is considered privileged and confidential. We will not release any information without your written authorization. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your clinician. If you would like us to work collaboratively with other professionals, such as physicians, teachers, other therapists, attorneys, etc., you may sign a release of information form authorizing this.

OFFICE HOURS

The office staff are typically available from 9:00 a.m. to 5:00 p.m. Monday through Friday. When the office staff is not available, you may leave a voice message for your clinician or email the clinician directly. We will assist you as soon as possible, but we do not provide 24 hour, on-call, emergency services. In these situations, you may seek help through a hospital emergency room, urgent care center, or by calling 911. If your clinician is out of town or unavailable for some other scheduled reason, one of our other clinicians will be available to help you. The first priority and our primary concern is your well being.

SCHEDULING APPOINTMENTS AND APPOINTMENT LENGTH

An appointment can be scheduled by either your clinician or our office staff. Child and adolescent intake appointments are typically 50-60 minutes and include an interview with parents/guardians only about the current difficulties and a review of the history of the problems. Sometimes adolescents participate in the initial intake, but often they will meet the clinician in the second appointment. Children meet the clinician in the second appointment.

Individual, couples, and family therapy are typically 45-50 minutes long. If an appointment runs longer, there is a charge for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

Appointments for psychological and psychoeducational testing may run 2-4 hours each, with 2-3 appointments needed in addition to the parent intake appointment. Results conferences following testing typically last 60-90 minutes depending on the extent of the testing.

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from seeing someone else in need. **Therefore, except in the case of an acute emergency, we require a 24 hour notice of any cancellation; otherwise, your account will be charged.** In addition, because insurance will not pay or reimburse for missed appointments, you will be held

financially responsible for these charges. If our office is closed, leave a voice message for the front office staff and contact your clinician directly by voice mail or email to inform us of your cancellation so the time may be used appropriately.

FEES AND INSURANCE REIMBURSEMENT:

Payment for professional services are due and payable at the time they are rendered. All clients are expected to take care of their fees at the time of the appointment. Any other arrangement is considered a special arrangement and must be discussed in advance with your therapist. We accept all major credit cards and checks. Many clients choose to have a credit card "on file" that is charged at the time of each appointment. Delinquent accounts may be referred to a collection agency.

All of our clinicians are "out of network" providers from the standpoint of insurance companies. If your insurance policy offers out-of-network mental health coverage, you may receive reimbursement from your insurance company if you choose to seek this yourself. Our office generally does not file insurance claims or accept payment from insurance companies. However, we can email you a statement for insurance reimbursement, called a "superbill," so that you may file claims. Many of our clients receive reimbursement for some or all of the costs of their services. Superbills and claims must be submitted to insurance companies in a timely manner, often within 90 days of the service or in the same year. Check with your insurance company to see what will be required.

ASSESSMENT AND/OR TESTING**:**

Testing is billed on the basis of the types of tests and the amount of time necessary to administer, score, analyze, interpret, and to report the results in written form. You will be provided with information about the types of tests and the cost prior to testing. If during the evaluation process it is discovered that additional testing is required to make a final diagnosis, you will be informed before any additional procedures are initiated. The written report, if requested, is generated after payment in full for testing services is received.

WRITTEN REPORTS, SUMMARIES, AND LETTERS:

Clinicians sometimes provide written reports, treatment summaries, and letters for clients. These are billed as separate procedures if they are done outside of a comprehensive psychological evaluation. Clinicians typically bill at their same hourly rate for writing as they do for providing psychological testing or therapy.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Child's Name _____ Date of birth _____

Parent/Guardian (print name) _____

Parent/Guardian Signature _____ Date _____

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INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES

I hereby voluntarily apply for and consent to psychological services from_____.
(Clinician's name)

This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving psychological services may include obtaining a professional opinion, reduction of psychological symptoms, and an increased understanding of psychological issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my child's difficulties, and limitations in the ability to make predictions based on results of psychological assessments (when applicable). I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to another mental health professional if I am not satisfied with my services.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the clinician to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the clinician
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold _____ harmless for releasing information under these conditions.
(Clinician's name)

Child's Name _____ Date of birth _____

Parent/Guardian (print name) _____

Parent/Guardian Signature _____ Date _____

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CONSENT FOR TELEHEALTH SERVICES

1. I understand that my clinician is providing telehealth services which may include telephone or video conferencing.

2. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

3. I understand that my clinician will take measures to protect the confidentiality of our telehealth appointments. At the same time, there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

4. I understand that my clinician or I can discontinue the telehealth appointment if it is felt that the telephone or video connections are not adequate for the situation.

5. I have had the opportunity to ask my clinician questions about telehealth. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me so that I understand them.

6. I understand that telehealth is NOT an Emergency Service and in the event of an emergency, I will call 911 or other appropriate agency providing emergency services.

7. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify that I have read or had this form read and/or had this form explained to me, that I fully understand its contents including the risks and benefits of the procedure(s), and that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. I understand I can revoke this consent at any time by written request.

Child's Name _____ Date of birth _____

Parent/Guardian (print name) _____

Parent/Guardian Signature _____ Date _____

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PERMISSION TO RELEASE AND OBTAIN INFORMATION

Complete this form if you want your clinician to consult with other individuals involved with your child's care.

I hereby authorize _____ to release and discuss the results of my child's
(Clinician's name)

____ Psychological Evaluation/Testing

____ Treatment/Therapy

with the following individuals. I give those listed below my permission to release and discuss information regarding my child to _____.
(Clinician's name)

This release of information is valid from _____ (date) to _____ (date).

Individual and Agency	Phone or email
1.	
2.	
3.	
4.	
5.	

Child's Name _____ Date of birth _____

Parent/Guardian (print name) _____

Parent/Guardian Signature _____ Date _____