Acct #:_____ Guar Acct #:_____ Date:_____

Attached: ❑ Hospice/HHA/NH/SNF Facility Info Form ❑ Accident/Injury Information Form ❑ ABN Form Send Demo info to EHR: ❑ Yes ❑ No

PATIENT INFORMATION

Patient:_____ Title: Mr./Mrs./Other:_____ Suffix: Jr./Sr./Other:_____
(Last / First / Middle)

Mailing Address:_____ _____ _____ _____
(Zip / City / State)

Physical Address:_____ _____ _____ _____
(Zip / City / State)

Home #:_____ Work #:_____ Ext:_____ Cell #:_____

Email:_____ Date of Birth:_____ Social Security #:_____

Sex: ☐ Male ☐ Female ☐ Unknown ☐ Other Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Preferred Language: ☐ English ☐ Spanish ☐ Unknown ☐ Decline to specify ☐ Other:_____

Race: ☐ Caucasian/White ☐ African American/Black ☐ Unknown ☐ Decline to specify ☐ Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Decline to specify

Current Employer:_____

Employment Status: ☐ Fulltime ☐ Self Employed ☐ Part Time ☐ Not Employed ☐ Unknown ☐ Retired ☐ Military Active

Student: ☐ Full Time ☐ Part Time ☐ N/A Prior Name:_____

Emergency Contact (EC) Name:_____ Relationship:_____

Home #:_____ Work #:_____ Cell #:_____

Have you seen a Physician at this practice within the past 3 years? ❑ Yes ❑ No If yes, which Physician?_____

Pharmacy:_____ Address:_____ Phone #:_____

Blood Type:_____ Notification Method: ☐ Mail ☐ Email ☐ Phone ☐ Text Patient & Resp Party are the same? ☐ Yes ☐ No

Referred By:_____

Do you have an advanced directive (living will, durable power of attorney)? ☐ Yes ☐ No → If 'Yes', provide copy:_____ _____
(Rec'd By / Date)

Is this an Accident or Injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No

If 'Yes' to either question, request and complete an Accident/Injury Information Form

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? ☐ Yes ☐ No

If 'Yes', request and complete a Hospice/HHA/NH/SNF Facility Information Form and ask about an ABN Form.

Are you or have you been incarcerated within the last year? ☐ Yes ☐ No → If 'Yes', please provide:

Facility Name:_____ Release Date:_____

RESPONSIBLE PARTY INFORMATION

ONLY COMPLETE IF OTHER THAN PATIENT, THIS IS WHERE STATEMENT/BILL IS SENT AFTER INSURANCE DISPOSITION

Responsible Party:_____ Title: Mr./Mrs./Other:_____ Suffix: Jr./Sr./Other:_____
(Employer Info if work related) (Last / First / Middle)

Mailing Address:_____ _____ _____ _____
(Zip / City / State)

Home #:_____ Work #:_____ Ext:_____ Cell #:_____

Email:_____ Date of Birth:_____ Social Security #:_____

Sex: ☐ Male ☐ Female Relationship to Patient:_____ Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Current Employer:_____

Employment Status: ☐ Fulltime ☐ Self Employed ☐ Part Time ☐ Not Employed ☐ Unknown ☐ Retired ☐ Military Active

INSURANCE INFORMATION

Scan/Copy Card

PRIMARY:	**SECONDARY:**
Relationship to Insured: ☐ Self ☐ Child ☐ Mate ☐ Other	Relationship to Insured: ☐ Self ☐ Child ☐ Mate ☐ Other
Insured: ☐ Patient ☐ Rsp Party ☐ Other	Insured: ☐ Patient ☐ Rsp Party ☐ Other
Insured Name:	Insured Name:
Social Security #: DOB:	Social Security #: DOB:
Group #: Policy#:	Group #: Policy#:
Eff Date: Exp Date:	Eff Date: Exp Date:
Contact:	Contact:
Phone:	Phone:
PCP (Name/Phone):	PCP (Name/Phone):

By signing this,

_____ (Initial) I hereby acknowledge THE EMERGE CENTER (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices for Protected Health Information (NOPP)*. I understand I have the right to restrict how my PHI is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

_____ (Initial) I hereby authorize THE EMERGE CENTER to evaluate and recommend any testing and/or additional treatment. I understand I have the right to refuse any such recommendations/treatment.

_____ (Initial) I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify all above information is true and accurate as of the below indicated date. I hereby authorize the listed insurance companies to pay directly to THE EMERGE CENTER benefits due on my behalf, if any, as provided in the above unexpired policy.

Signature:_____ Date:_____ Witness Signature:_____ Date:_____

Printed Name:_____ ☐ Patient ☐ Responsible Party

Authorization for Release of Information

Client Name: _____ DOB:_____

I understand that this authorization is voluntary. I understand that I may revoke this consent at any time by sending a written notice to The Emerge Center. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the agency named above.

I hereby authorize the Emerge Center to:

☐ Exchange with ☐ Release to ☐ Obtain from **the parties I have indicated below**

I authorize the Emerge Center to exchange/ release/ obtain information in the following manner:

☐ Verbally only ☐ in written form only ☐ both verbally and in writing

Persons/ organization receiving/ communicating the information:

Name _____

Address_____

_____

Phone Number (_____) _____ ext: _____

This consent is valid for 1 year from the date on this form or a date specified in the notes section:

Notes: _____

_____

Signature of Client or Legal Guardian Date

_____

Address City State ZIP

_____

Printed name of client/guardian Relationship if not the parent

the emerge CENTER
for communication, behavior, and development

Consent for Assessment and Treatment

Client Name _____ Client Date of Birth _____

I voluntarily consent to the assessment and the treatment offered by the Emerge Center. I give my permission for the staff of the Emerge Center to perform the following service(s):

Testing/ assessment and/or treatment from staff of the Emerge Center in the following departments:

☐ Speech Therapy assessment and/or treatment

☐ Audiology Services

☐ Psychological assessment and/or treatment

☐ Applied Behavior Analysis therapy

☐ Occupational Therapy assessment and/or treatment

☐ Specialized consultation:_____

☐ Other: _____

This consent is for
___ Myself
___ My family member (Name _____)
___ Other (Explain: _____)

I have been informed that I, my family member, or the interdict will receive testing and/or treatment from Emerge Center. These procedures may involve, but are not limited to: tests of cognitive, speech/language, perceptual, physical, memory, and social/emotional functioning. I understand that during the interview-intake process, I will be asked about the symptoms and history related to my, my family member's, the interdict's present problem. I have been informed about confidentiality and its limits.

Further (initial in each blank to indicate that you have read the item and consent to the statement):

___I understand that services will be provided by employees of the Emerge Center and its Contractors and that, upon my signature, my, my family member's, the interdict's confidential information may be discussed among Emerge Center employees in pursuit of the highest quality of assessment and/or treatment.

___I understand that this consent may be rescinded or modified at any time with a written request to the Emerge Center.

___I understand that these services may include direct, face-to-face contact, interviewing, records review, consultation with other professionals, and other related activities necessary to support these services.

___I understand that there will be no exchange of printed or verbal information outside the Emerge Center without an appropriate release of information that I review and sign.

___I understand and agree to, for professional training purposes, supervised students observing and/or participating in the rendering of my, my family member's, the interdict's services.

___ As part of the student/clinician training process, for reasons related to safety, and/or for consultation with other professionals under Emerge Center, I understand and agree to the live monitoring or taping for review upon a later date as needed, the video recording of the provision of services for which I am herein providing my consent

___ I consent to telehealth service performed by an Emerge Center provider when scheduled. During telehealth services:

- Nonmedical technical personnel may be present to aid in video transmission. I will be informed of any other people who are present at the telehealth encounter.
- Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associate with the telehealth service

___I understand all information client information strictly confidential. The legal exceptions are:

- The client, parent/guardian or legal representative authorizes a release of information with a signature
- To comply with a court order
- There is suspicion of abuse or neglect involving a child, elder, or vulnerable person.
- The client presents as a danger to self or others
- Record review as requested by insurance carrier provided authorization has been obtained.

_____ _____

Signature of Individual or Personal Representative by Law Date

_____

Personal Representative's Relationship/Authority

_____ _____ _____

Signature of Emerge Center Representative Date

NOTE: If the individual is a competent major, he or she is to sign, or make his or her mark on the first line. If the individual is a minor, incompetent major, or unable to sign, the parent, guardian, or correspondent is to sign on the first line and fill in the second line

NOTICE OF PRIVACY PRACTICES
THE EMERGE CENTER

This notice describes how medical or other identifying information obtained by our practice about you may be used and disclosed and how you can get access to this information. Please review this statement carefully and keep a copy to take home.

The Emerge Center is required by professional ethics and federal law to keep confidential all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally. You, the client, have significant rights to understand in order to control how your health information is used. This agency may be penalized if we misuse your personal health information.

Who Will Follow This Notice

All employees, independent contractors, officers and directors of The Emerge Center must abide by this notice.

How We May Use and Disclose Your Personal Health Information
We may use and disclose your personal health information only for each of the following purposes: **treatment, payment, & health care operations.** Examples are given for each purpose, but they are not intended to imply that they are the only uses in that category.

- **Treatment** means providing, coordinating or managing the services you have requested. Example: If we order a hearing aid for you, we may disclose the results of your audiogram.
- **Payment** means such activities as obtaining reimbursement for services, determining your eligibility for insurance coverage, billing or collection activities and utilization review. Example: If you are eligible for Medicaid, we will send an invoice for your services to them for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducing quality assessment and improvement activities, auditing our financial statements, etc. Example: Independent auditors must review agency invoices against payment of those invoices.

Other Uses & Disclosures of Protected Health Information Requiring Your Written Authorization
We may disclose personal health information

- as required by law or statute, including disclosure to public health or designated authorities charged with preventing or controlling disease, injury or disability; licensing & regulatory agencies, authorities investigating domestic violence or abuse or neglect;
- in response to a subpoena or court order;
- to a coroner or medical examiner for identification of a body;
- to the extent allowed by federal law, to other providers' treatment and healthcare operations activities.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

(OVER)

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
Any other uses and disclosures of protected health information not covered by this notice or by other applicable laws will be made only with your written authorization. If you give us authorization to use or disclose any of your protected health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose that information for the reasons previously covered by your written authorization. However, we would be unable to take back any disclosures already made with your authorization, and we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information
You may exercise any of the following rights with respect to your protected health information by presenting a written request to the Executive Director of The Emerge Center:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. We reserve the right to charge you for the net cost of copying your records.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
- If you believe your privacy rights have been violated, you may file a complaint with the Executive Director of The Emerge Center or with the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or denied service for filing a complaint.

The Emerge Foundation on behalf of the Emerge Clinic may notify you of fundraising opportunities. You have the right to opt-out of receiving such fundraising communications. If you do not want to receive these communications you can send us an email at giving@emergela.org with the words “Opt Out” in the subject line. Be sure to include your name or the name of the patient (if you are the patient’s parent or acting in loco parentis). If it is more convenient, you can call us at (225) 343-4232 ext. 1911 and leave a message with the patient’s name stating that you wish to “Opt Out” of receiving fundraising communications. If you decide to Opt-Out of receiving fundraising communications, you cannot be denied treatment and that will not affect payment.

This notice is effective as of August 12, 2019. We are required to abide by its terms. Within the provisions of law, we reserve the right to change the terms of this notice and to make the new terms effective for all protected health information that we maintain. We will post, and you may request, a written copy of a revised Notice of Privacy Practices from our office if such a change should occur.

To request more information or file a complaint regarding these practices with the Department of Health & Human Services, Office of Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201 or Phone Toll Free: 1-877-696-6775

Client/Guardian Signature _____Date: _____

Client/Guardian Name _____

Minor Client Name _____

Permission to Email Confidential Information

We strive to communicate with parents and caregivers through the best method possible. For many families, email is a preferred method for communication. If you allow us to email with you through your designated email listed below, please sign and date. Please be aware that confidentiality cannot be assured via e-mail.

E-mail address(es): _____

_____

Parent name/s: _____

Parent Signature: _____

Child's Name:_____

Date: _____

Emerge Center Intake Form

Please complete this form to the best of your knowledge. This form is used for clients between the ages of birth and 18-years-old. Therefore, not all questions will apply to your child. If a question does not apply, please write NA for Not Applicable. A space will be provided at the end of the document if you need more space or wish to make additional comments.

Today's Date: _____

Child's Name:	
Date of Birth:	**Current Age:**
Race/Ethnicity:	**Sex:** ☐ Male ☐ Female ☐
School Name:	**Grade:**

Referral Details

Referral Source: ☐ Pediatrician ☐ Other medical provider ☐ Specialist (Speech, OT, Audiologist)
☐ Self-Referral ☐ Teacher/School ☐ Other (Please list: _____)

Name of Referring Provider or Person: _____

What services are you seeking at the Emerge Center?

☐ **Speech and Language**

☐ **Applied Behavior Analysis (ABA)**

☐ **Occupational Therapy**

☐ **Audiology**

☐ **Behavioral Health**

Please tell us about your **MAIN** concerns:

Parent(s)/Guardian(s) Information

Parent/Guardian 1: ☐ Mother ☐ Father ☐ Biological ☐ Adoptive ☐ Foster ☐ Other

If other, please indicate:

Name:	
Date of Birth:	
Occupation:	
Place of Employment:	

For biological parent, is there a history of:

☐ Learning problems ☐ Attention problems ☐ Behavioral problems ☐ Emotional and/or psychiatric problems ☐ Other, please list (e.g., speech delays, developmental delays, autism, etc.):

Parent/Guardian 2: ☐ Mother ☐ Father ☐ Biological ☐ Adoptive ☐ Foster ☐ Other

If other, please indicate:

Name:	
Date of Birth:	
Occupation:	
Place of Employment:	

For biological parent, is there a history of:

☐ Learning problems ☐ Attention problems ☐ Behavioral problems ☐ Emotional and/or psychiatric problems ☐ Other (e.g., speech delays, developmental delays, autism, etc.)

Describe any developmental delay, behavioral, emotional, or psychiatric problems of blood relatives not listed above:

Marital Status of the Child's Parent(s)/Guardian(s):	*If not married, does the other parent/guardian have:*
☐ Never Married ☐Married, ☐Divorced, ☐Separated, ☐Live with partner, ☐Other	☐ Sole Custody ☐ Shared or Joint Custody ☐ Visitation ☐ Supervised Visitation ☐ No Visitation Rights ☐ Other
If other was selected please describe/explain:	
Please list when married, divorced, or separated:	
Who is the child's legal guardian(s)?	
*******IMPORTANT: A legal guardian must be present at initial appointment. If there is joint or shared custody, please bring copies of legal documentation of custody arrangement. ********	

Home Environment

Child Lives with (check all that apply):

☐ Biological Mother ☐ Adoptive Mother ☐ Foster Mother ☐ Mother's Spouse/Partner ☐ Maternal Grandparents
☐ Biological Father ☐ Adoptive Father ☐ Foster Father ☐ Father's Spouse/Partner ☐ Paternal Grandparents
☐ Siblings - if selected: How many siblings living in the home with the child? _____
☐ Other (please list): _____

Siblings: Please list all siblings

Relationship (i.e., full, half, step-sibling)	Age	Sex	Medical, Developmental, Social, Emotional, Behavioral or School Problems?
		☐ Male ☐ Female ☐	
		☐ Male ☐ Female ☐	
		☐ Male ☐ Female ☐	
		☐ Male ☐ Female ☐	
		☐ Male ☐ Female ☐	
		☐ Male ☐ Female ☐	
If the child has more siblings than the space provided please include here:			

If your child was adopted, please indicate:	Year of adoption:		Child's age at adoption:	

Background History

PREGNANCY

Duration of pregnancy (number of weeks): _____
Any complications during pregnancy? ☐ Yes ☐ No
Check all that apply: ☐toxemia ☐high blood pressure ☐excessive vomiting ☐gestational diabetes
☐ Other (please describe): _____
Was bed rest required? ☐ Yes ☐ No
Was hospitalization required? ☐ Yes ☐ No
Medications during pregnancy? ☐ Yes ☐ No
Please list: _____
Any substances use during pregnancy? ☐ Yes ☐ No
☐ Alcohol ☐ Nicotine ☐ Illegal substances ☐ Other: _____

If applicable please list type, frequency, amount, and duration of use during pregnancy:

DELIVERY

Birthweight: _____ lb _____ oz
Labor Type: ☐ spontaneous ☐ induced
Labor Duration (hours): _____
Delivery Type: ☐ Vaginal ☐ Caesarean section (C-section)
Complications during delivery (select any that apply):
☐ cord around neck ☐ hemorrhage ☐ Meconium aspiration ☐ Injury during delivery
☐ Other (please describe) _____

POST DELIVERY PERIOD

Complications: ☐ Yes ☐ No If yes, please select all that apply
☐ Jaundice ☐ cyanosis (turned blue) ☐ infections (please describe below) ☐ Other (please describe below)

☐ Required NICU care
Number of Days infant was in the hospital after delivery? _____

INFANCY

Were any of the following present, to a significant degree, during the first few years of life?

☐ Did not enjoy cuddling	☐Excessive irritability
☐ Was not calmed by being held or stroked	☐ Diminished Sleep
☐ Difficult to comfort	☐ Difficulty nursing/feeding
☐ Colic	☐ Excessive restlessness
☐ Reflux	☐ Frequent head-banging
If selected, please describe if necessary:	

TEMPERMENT (During infancy & toddlerhood) MAKE IS/WAS

How active has your child been from an early age? ☐ Overactive ☐ underactive ☐ within normal limits

Was your child's attention very easily diverted? ☐ Yes ☐ No

How well did your child respond to new stimuli (places, people, food, routines)? ☐ No difficulties ☐ Difficulties

Please Describe:

Whether happy or unhappy, how aware were others of your child's feelings? ☐ Aware ☐ Unaware

How predictable was your child in patterns of sleep, appetite, etc.? ☐ Predictable ☐ unpredictable

Was your child over- or under-sensitive to light, sound, textures?

☐ Oversensitive ☐ under sensitive ☐ within normal limits/no concern

Select all that apply: ☐ movement ☐ light ☐ sound ☐ texture ☐ taste ☐ smell ☐

Please Describe:

Please list your child's age that he/she met each of these developmental milestones.		
	Age (in Months)	Not Currently Met
Sitting		☐
Crawling		☐
Walking		☐
Spoke First Word		☐
Spoke in Phrases		☐
Toilet Trained		☐

CHILD'S MEDICAL HISTORY

Does your child have any medical diagnoses? ☐ No ☐ Yes If yes, please list diagnosis, date given & diagnosing provider:

Serious illness or trauma: ☐ No ☐ Yes If yes, please list type, age, and describe:

Additional:

Hospitalization: ☐ No ☐ Yes

Please describe - list beginning and end dates and reason for hospitalizations:

Surgical History: ☐ No ☐ Yes ☐ PE tubes ☐ adenoidectomy ☐ tonsillectomy ☐ appendectomy

☐ other: (please list type and age): _____

Convulsions/seizures ☐ No ☐ Yes

Head injuries ☐ No ☐ Yes

Persistent high fevers ☐ No ☐ Yes

Poisoning ☐ No ☐ Yes

Allergies ☐ No ☐ Yes

☐ Seasonal

☐Food Allergy: allergen _____ type of response_____
☐ Other allergen _____ type of response_____
Has your child ever had an adverse reaction to a food or medication? ☐ No ☐ Yes
If yes: Please list item _____and type of reaction_____
Asthma: ☐ No ☐ Yes
Tics (i.e., eye blinking, sniffling, or any repetitive, non-purposeful movements) ☐ No ☐ Yes
Ear/Hearing Problems**:** ☐ No ☐ Yes Wears hearing aid: ☐ No ☐ Yes ☐ other device _____
Eye/Vision Problems**:** ☐ No ☐ Yes
Wears glasses**:** ☐ No ☐ Yes Reason: ☐ nearsighted ☐ farsighted ☐ other _____

Please check below if your child currently or previously took medication for any of the listed concerns:

	Now	Past		Now	Past
Attention	☐	☐	Aggression	☐	☐
Depression	☐	☐	Behavior Problems	☐	☐
Anxiety	☐	☐	Sleep	☐	☐
Mood	☐	☐	Tics	☐	☐

Current medication(s): ☐ No ☐ Yes:
Type/Dosage/Frequency: _____
Began: _____
Prescriber: _____
Effectiveness: ☐ Effective ☐ Not effective ☐ Unknown
Compliance ☐ No ☐ Yes
Side effects: ☐ No ☐ Yes: list: _____

Please provide the following information for regarding your child's pediatrician:
Pediatrician's Name: _____ Address:_____
Phone: _____

Other physicians that your child currently sees (e.g., neurologist, ENT, GI):
☐Neurologist, ☐ENT, ☐Gastroenterologist (GI) ☐Other (please list: _____

MENTAL HEALTH HISTORY

Has your child previously had psychological or educational testing through school or another agency? ☐Yes ☐No
If yes, **please bring copies of <u>ALL evaluations</u> to your intake appointment. ****

If yes, please list date and reason for testing:
_____

Has your child previously seen or currently sees a mental health provider such as a ☐Psychiatrist, ☐Psychologist, ☐Social Worker, ☐Therapist, or ☐Counselor? ☐Yes ☐No

If yes, please list start and end dates of services, reason for service, and your child's response to the service:
_____

Has your child ever been hospitalized for psychiatric concerns? ☐Yes ☐No

If yes, please list dates of hospitalization and reason for hospitalization:
_____

Does your child have any mental illness diagnoses? ☐Yes ☐No

If yes, please list diagnosis, date given, and diagnosing provider for each.
_____

THERAPEUTIC HISTORY

Has your child previously received testing for Speech, Occupational therapy, or ABA through the school or another agency? **If yes**, **please bring copies of <u>ALL evaluations</u> to your intake appointment. **	☐Yes	☐No
If yes, please list date and reason for testing: _____		
Has your child ever received **Speech therapy**? **If yes,** please list the start date of services, provider name and agency, and your child's response to treatment: _____	☐Yes	☐No
Has your child ever received **Occupational** therapy? **If yes,** please list the start date or services, provider name and agency, and your child's response to treatment: _____	☐Yes	☐No
Has your child ever received **Physical** therapy?	☐Yes	☐No
If yes, please list the start date or services, provider name and agency, and your child's response to treatment: _____		
Has your child ever received **Early Step Services**?	☐Yes	☐No
If yes, please list the start date or services, provider name and agency, and your child's response to treatment: _____		
Has your child ever received **Applied Behavior Analysis (ABA)?**	☐Yes	☐No
If yes, please list the start date or services, provider name and agency, and your child's response to treatment: _____		
Has your child been evaluated by your local school system's Pupil Appraisal Office?	☐Yes	☐No
****If yes,** please bring copies of the **Pupil Appraisal Evaluation** to the intake appointment. **		
Does your child have an **Individualized Education Plan** (IEP) or 504 Plan through the local school system?	☐Yes	☐No
****If yes,** please bring a copy of the **IEP/ 504 Plan** to the intake appointment. **		
If your child is school age, has your child ever participated in any of the following programs?		
Gifted and Talented	☐Yes	☐No
Advance Academic Curriculum	☐Yes	☐No
Adaptive Physical Education	☐Yes	☐No
Content Mastery	☐Yes	☐No
School Based Counseling	☐Yes	☐No
Resource Room Services	☐Yes	☐No
Alternative School Placement	☐Yes	☐No
Alternative Academics	☐Yes	☐No
Self-Contained Classroom/ Low Numbers Class	☐Yes	☐No
Reverse Mainstream Classroom	☐Yes	☐No
Life Skills Class	☐Yes	☐No

SOCIAL HISTORY

Are there any major stressors or family changes affecting your family or your child? ☐Yes ☐No

Select any that apply: ☐deaths, ☐ job change, ☐school change,☐ physical or sexual abuse, ☐separation or divorce, ☐use of drugs or alcohol in the family
☐ Other *please describe:* _____

Does your family have any spiritual, cultural, or religious beliefs that influence your child's care with us that we need to be aware of? ☐Yes ☐No

Does your family have any financial concerns? ☐Yes ☐No

Does the family have any transportation concerns? ☐Yes ☐No

Are there any relevant legal issues with the client and/or family that would affect services provided by The Emerge Center? ☐Yes ☐No

If you answered yes to any question in the **social history section**, please provide additional details here:
Please describe your child's **strengths**:
Please describe your child's **weaknesses**:
Please describe your child's **favorite activities/extracurricular activities**:

ADDITIONAL COMMENTS:

Behavioral Health Only

If you indicated that you are interested in Behavioral Health services, please complete this section:

What services are you seeking to receive from the Emerge Behavioral Health Department? (check all that apply)

Assessment/Testing Evaluation:
- ☐for ADHD
- ☐for Autism Spectrum Disorder
- ☐for Problems with Development
- ☐for Depression
- ☐for Anxiety
- ☐for Academic Problems
- ☐Other:

Treatment/Intervention
- ☐Individual Therapy
- ☐Parenting/Behavior Management
- ☐Help with Sleeping
- ☐Help with Feeding
- ☐Help with Potty Training
- ☐Anger Management
- ☐Social Skills Training
- ☐Other:

To help us understand your concerns, please check all that apply:

My child has unusual behaviors
- ☐Repeats the same behavior over and over plays with toys in unusual ways (lines things up, counts them)
- ☐Gets stuck on certain activities/topics
- ☐Is especially sensitive to the sight, feel, sound, taste, or smell of things
- ☐Flaps his/her hands
- ☐Is interested in unusual things (paper clips, bottle caps, stop signs, string)
- ☐Has trouble with change or transitions
- ☐Repeats lines from movies, TV, etc.
- ☐Uses your hand to show wants and needs
- ☐Has odd movements or tics

My child has trouble with attention:
- ☐Has trouble concentrating
- ☐Has a short attention span/is very distractible

I have concerns about my child's mood:
- ☐Seems depressed or unhappy
- ☐Seems too irritable
- ☐Has sleep or appetite changes
- ☐Is moody or has mood swings
- ☐Has extreme happiness

My child seems anxious or nervous:
- ☐Is too shy
- ☐Is repeatedly bothered by upsetting thoughts (germs, illness, horrible events, "bad" thoughts, etc.)
- ☐Feels driven to do things over and over (wash, check, count, confess, arrange, even, collect, etc.)
- ☐Is too anxious in social situations
- ☐Has frequent nightmares
- ☐Seems to worry too much
- ☐Has trouble separating from parents/loved ones
- ☐Has unusual fears or phobias

I have concerns about my child's development:
- ☐Language delays or regression
- ☐Motor delays or regression
- ☐Toileting problems
- ☐Problems with feeding

My child has social difficulties:
- ☐Is teased or bullied
- ☐Prefers to be alone
- ☐Is not interested in having friends
- ☐Is mean to other children
- ☐Has poor eye contact

My child has problems thinking:
- ☐Has unusual or false beliefs
- ☐Hears or sees things
- ☐Feels like others are out to get him

My child has trouble learning/at school:
- ☐With letter identification or reading
- ☐With spelling or writing
- ☐With math
- ☐With memory

My child has behavior problems:
- ☐Is easily frustrated
- ☐Acts impulsively
- ☐Is overly active
- ☐Is aggressive
- ☐Has been suspended/expelled from school
- ☐Does not obey
- ☐Breaks rules
- ☐Is in legal trouble
- ☐Uses drugs or alcohol
- ☐Is overly focused on weight loss
- ☐Diets or exercises too much
- ☐Uses vomiting or other things to get rid of food he/she has eaten

On a scale of 1-5, please rate your child's mental health state:

☐1	☐2	☐3	☐4	☐5
Poor		Average		Excellent

On a scale of 1-5, please rate your child's quality of life:

☐1	☐2	☐3	☐4	☐5
Poor		Average		Excellent

On a scale of 1-5, please rate your family's quality of life:

☐1	☐2	☐3	☐4	☐5
Poor		Average		Excellent

Thank you for taking the time to provide this information! We look forward to working with your child and family!

Sincerely,

Emerge Center Staff