Please fill out this form in as much detail as possible. We appreciate your taking time to provide us with this information which will help us understand your concerns and make an accurate diagnosis.

IDENTIFYING INFORMATION

Name of person completing the form_____
Last *First*

Relationship to the Client_____

Client's Name_____
Last *First* *Middle Initial*

Age_____ Date of Birth ___/____/____ Place of Birth_____
(mm/dd/yyyy) *City/US State/Country*

Education_____

Occupation_____

Home Street Address_____

City _____State_____ Zip_____

Home Phone Number_____ Alternate Phone Number_____

Emergency Contact Person's Name_____ Phone_____

MEDICAL AND HEALTH INFORMATION

Current Height_____ Current Weight_____

Have you had any surgery, serious illnesses or accidents _____ Yes_____ No

Do you have allergies? (Environmental or food allergies) _____Yes _____No

Do you have asthma or any other respiratory problems? _____Yes _____No

Do you have any medical conditions? _____ Yes _____No

If you answered yes to any of the above questions, please explain: _____

_____

_____

Do you take any medications regularly? _____Yes _____No

If yes, please list: _____

_____

Have you ever been examined by:

Ear, Nose, and Throat Doctor? _____Yes_____ No

Neurologist? _____Yes _____No

Psychologist? _____Yes_____ No

Other Medical Specialist _____Yes _____No

If yes, please explain reason for visit and outcome: _____

_____

Please give place and dates of any previous evaluations or therapy:

Hearing: _____

Vision: _____

Physical Therapy: _____

Occupational Therapy: _____

Psychotherapy:_____

Other:_____

Briefly describe any behavioral problems that you are facing at home/work_____

_____

_____

7340, Heritage Village Plaza, Suite 102, Gainesville, VA 20155
Phone: 703-398-1085, Fax: 866-299-2424

Are there any past or present circumstances which you think could be related to your present difficulties?_____

_____

Have you ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)? _____Yes_____ No

If yes, please describe _____

_____

Do any family members have (or have had) a psychological disorder?_____ Yes____ No

If yes, who and what kind? _____

Please put any other comments that will help us understand you better_____

_____

_____

_____

_____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for evaluation / treatment by Behavioral Care Services for myself and/or my family members.

Patient/Parent/Guardian Signature_____

Printed Name: _____

Date:_____

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