Chart No. _____
Revised August, 2018

CAROLINA BEHAVIORAL CARE

CHILD/ADOLESCENT PATIENT REGISTRATION FORM

Today's Date _____

Patient Name _____ Patient Sex: M F Identify as: _____

Patient DOB _____ Patient Age _____ Patient SSN: _____

Parent(s)/Guardian(s)*:* _____

Mailing Address: _____

City _____ State_____

Zip_____

Home Phone_____ Cell Phone_____ Work phone_____

E-mail _____

Preferred method of communication for reminder calls: ____Calls ____Texts ____ E-mails

Patient's School & Grade Level: _____

Patient's Occupation, if applicable: _____

Primary Care Provider Name & Telephone: _____

May we communicate with patient's Primary Care Provider about patient's care? **YES NO**

Please list the names and contact information for any other health care providers, individuals, or groups you would like us to communicate with regarding patient's care at CBC:

_____

_____

Emergency Contact (Name): _____

Address_____ Phone _____ Relationship _____

Who can we thank for referring you to CBC? _____

Which Pharmacy does patient use?_____ **Phone #** _____

Does patient have health insurance coverage? Yes No

Does patient have prescription insurance coverage? Yes No

GUARANTOR INFORMATION (person responsible for this account)

Name_____Relationship_____Date of Birth_____

Mailing Address _____

Social Security No. _____ Employer (group insurance)_____

SIGNATURE REQUIRED FOR ALL PATIENTS

PATIENT/GUARANTOR SIGNATURE: _____ Date: _____

CBC Chart No: _____
Today's Date: _____

How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

1. Feeling down, depressed, irritable, or hopeless?

0 – None at All	1 - Several Days	2 – More than half the days	3 – Nearly every day

2. Little interest or pleasure in doing things?

0 – Hardly Ever	1 - Much of The Time	2 – Most of The Time	3 – All of The Time

3. Trouble falling asleep, staying asleep, or sleeping too much?

0– Hardly Ever	1 - Much of The Time	2 – Most of The Time	3 – All of The Time

4. Poor appetite, weight loss, or overeating?

0– Hardly Ever	1 - Much of The Time	2 – Most of The Time	3 – All of The Time

5. Feeling tired or having little energy?

0– Hardly Ever	1 - Much of The Time	2 – Most of The Time	3 – All of The Time

6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down.

0– Hardly Ever	1 - Much of The Time	2 – Most of The Time	3 – All of The Time

7. Trouble concentrating on things like school work, reading or watching TV?

0– Hardly Ever	1 - Much of The Time	2 – Most of The Time	3 – All of The Time

8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?

0– Hardly Ever 1 - Much of The Time 2 – Most of The Time 3 – All of The Time

9. Thoughts that you would be better off dead, or of hurting yourself in some way?

0– Hardly Ever 1 - Much of The Time 2 – Most of The Time 3 – All of The Time

In the <u>past year</u>, have you felt depressed or sad most days, even if you felt okay sometimes? *(Circle your answer)* YES NO

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? *(Circle your answer)*

NOT DIFFICULT	SOMEWHAT DIFFICULT	VERY DIFFICULT	EXTREMELY DIFFICULT

****Has there been a time in the <u>past month</u> when you have had serious thoughts about ending your life? Circle YES or NO**

YES NO

Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? Circle YES or NO

YES NO

Office Use Only _____ Severity Score: _____

Patient Name: _____ CBC Chart No: _____
Patient DOB: _____ Today's Date: _____

PATIENT'S ALLERGIES

Do you have allergies to anything, including food, medications, etc.? Yes No
Circle all that apply. If your allergy is not listed, please write it in the Other section below.

Acetaminophen	Demerol	Penicillin
Ampicillin	Eggs	Pollen
Anesthesia	Ibuprofen	Prednisone
Antihistamines	MAOI's	Salicylates
ASA	Morphine	SSRI's
Barbiturates	No known allergies	Sulfa drugs
Chocolate	No known drug allergies	TCA's
Codeine	NSAIDs	Tetanus vaccine
Dairy products	Peanuts/Tree Nuts	Other:

PATIENT'S MEDICATIONS

Do you take prescribed or OTC medications, supplements, or vitamins? Yes No
If yes, please list the name, daily dose, prescriber, status, and reason for each one below.

Name of medication, vitamin, or supplement	**Daily Dose**	**Prescribed By**	**Active or Stopped** (circle one)	**Reason you take this medication** (name of illness, disease, etc.)
			Active Stopped	
			Active Stopped	
			Active Stopped	
			Active Stopped	
			Active Stopped	

PATIENT'S FAMILY HISTORY

Have you, your siblings, your parents or grandparents had any of the following issues?

YES NO. If yes, circle any issues you (Self) or your family (F) have had and put a √ if the issue is yours and/or a family member's. *Circle all that apply.*

	Self	Family
Alcoholism		
Alzheimer's		
Anemia		
Anxiety disorder		
ADD		
Autism		
Bipolar disorder		
Cardiac Arrhythmia		
Cardiac disease		

	Self	Family
Dementia		
Depression		
Diabetes		
Down's syndrome		
Endocrine disease		
Enuresis		
Headaches		
High cholesterol/lipids		
Jail or Prison		

	Self	Family
Learning disability		
Mental retardation		
Schizophrenia		
Stroke		
Substance Abuse		
Suicidal attempts		
Thyroid disease		
Ulcerative colitis		
Other:		