BEHAVIOR MANAGEMENT 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
Severe Behavior Disorders 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 bring the following additional information to the 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:______________________________

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? Y/N

Address:____

City, State, Zip:____

Telephone: (Cell)_______________ (Home)____________________(Work) __________________

Email Address: ____

____

Who lives in the home?

____

Name of Primary Care Physician:____

Affiliation:____

Address:____

Telephone:____

Name of School:____

Grade:________________

Teacher:____

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_____

Presenting Problem

List the top three behavioral concerns:

1. ____
2. ____
3. ____

Goals for treatment:

____

____

____

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, etc.)?
Yes No

If yes, please list them here:
____

Medical and Family History

Birth History

How many weeks pregnant were you when your child was born? ______________________

Was your child born by vaginal delivery or C-section? _______________________________

What was your child's birth weight/length? __________lbs _________in.

Were there any problems at birth? ____

Were there any problems during pregnancy? ____

Previous Illnesses:____

Past surgeries/hospitalizations:____

Most recent hearing screen: ________________; Results:____________________________________

Most recent vision screen: _________________; Results:______________________________________

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

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

List any immunizations not up-to-date:____

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

Dates/Providers of previous treatment: ____

Current treating clinician:____

Current therapeutic intervention/response: ____

Is there a history of intellectual disability (ID) or developmental disability in your family?
Yes No

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:

____

Please write the approximate age that your child developed the following behaviors: (please check)

Babble:________Use single words:________Use short phrases:________Use sentences:________
Toilet trained during day:________Toilet trained at night:________Roll over:________
Sit independently:________ Take first steps:________Play games (like peek-a-boo): ________
Crawl: ________ Smile: ____

As an infant/toddler, was your child: (please check)

Interested in people____Overly active____ Easy to please____ Irritable/Cranky____
Difficult to nurse or feed____Interested in toys____ Able to be flexible with change in routine____
Underactive____Difficult to soothe____Resistant to touch____Reactive to certain noise

What is the client's primary form of communication? (please check)

Gestures:______Picture Exchange:______Sign Language:______Vocal Language:______ Other:____

Which one best describes your child's mental abilities? (please check)

Normal Intelligence______ Mild Intellectual Disability ______Moderate Intellectual Disability______
Severe Intellectual Disability______

Can your child? (please check)
Respond to his/her name? ______ Imitate words you say?______
Imitate words/sounds from their favorite videos?______ Label things that he/she sees? ______
Label things that he/she feels? ______ Label things that he/she smells? ______
Follow one step directions?______Respond to "what" questions?______
Respond to "where" questions?______Respond to "why" questions? ______
Respond to "how" questions?_____Tell you what happened during the day?_____
About how many questions can the client respond to?_____
Feed self ______Dress self_____Bathe self_____Tie shoes_____Walk on their own_____
Walk up/down stairs _____Stay close to caregiver in public places_____
Imitate things you do_____

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: ____

Destructive Behavior Severity Scale

Please read the definitions of problem behavior below and mark how often it occurs and the highest level of severity with which it occurs. If your child does not display that type of behavior, please leave it blank.

Aggression involves forceful pushing or striking others with body parts (e.g., pushing, hitting, kicking, head-butting); hitting others with objects; or scratching, pinching or biting others.

☐Never ☐ Monthly ☐Weekly ☐Daily ☐Hourly ☐Over 5 per Hour ☐Over 10 per Hour

☐Level 1 = resulting in (a) no marks on body and (b) no blows close to or contacting the eyes.

☐Level 2 = resulting in (a) reddening of skin, and/or (b) mild swelling.

☐Level 3 = resulting in (a) light scratches, (b) small or shallow breaks in skin, and/or (c) moderate to severe swelling.

☐Level 4 = involving blows close to or contacting the eyes or resulting in (a) scratches that leave scars, (b) breaks in skin that leave scars, and/or (c) trauma resulting in broken bones or lasting tissue damage or disfigurement.

Self-injurious Behavior (SIB) involves forceful striking, scratching, rubbing, poking or biting own body parts such that repetition of the behavior over time has or will cause bodily injury (e.g., hitting, kicking, pinching, scratching or biting self biting, eye poking); banging body parts against objects (e.g., head-banging).

☐Never ☐ Monthly ☐Weekly ☐Daily ☐Hourly ☐Over 5 per Hour ☐Over 10 per Hour

☐Level 1 = resulting in (a) no visible marks on body and (b) no blows close to or contacting the eyes.

☐Level 2 = resulting in (a) reddening of skin, and/or (b) mild swelling.

☐Level 3 = resulting in (a) light scratches, (b) small or shallow breaks in skin, and/or (c) moderate to severe swelling.

☐Level 4 = involving blows close to or contacting the eyes or resulting in (a) scratches that leave scars, (b) breaks in skin that leave scars, and/or (c) trauma involving broken bones or lasting tissue damage or disfigurement.

Property Destruction involves banging, kicking, throwing, overturning, tearing, cutting, defacing, burning or stomping on objects not made for that purpose.

☐Level 1 = resulting in disruption of property but no permanent damage to paper items, toys, teaching materials, furniture, vehicles or buildings.

☐Level 2 = resulting in damage to paper items or other light objects.

☐Level 3 = resulting in (a) breakage of pencils, plastic toys, glassware, or other breakable items, and/or (b) scratches or permanent marks on furniture, walls, cars, etc.

☐Level 4 = resulting in structural damage to furniture, cars, walls, etc.

<u>Injury Risk Behavior</u> involves frequently engaging in dangerous behaviors without recognizing the potential hazards, such as: (a) climbing on objects where falling is probable; (b) running into a street without watching for cars; (c) pulling down objects onto oneself; (d) touching electrical wires, stoves or other dangerous items; (e) drinking or eating dangerous fluids

☐Never ☐ Monthly ☐Weekly ☐Daily ☐Hourly ☐Over 5 per Hour ☐Over 10 per Hour

☐Level 1 = resulting in no: (a) marks on body, (b) burns, (c) gagging, (d) vomiting, or (e) choking.

☐Level 2 = resulting in: (a) reddening of skin or mild swelling; (b) a 1st degree burn; and/or (c) mild gagging.

☐Level 3 = resulting in: (a) light scratches, small or shallow breaks in skin, moderate to severe swelling; (b) a 2nd degree burn; (c) vomiting or significant choking.

☐Level 4 = resulting in: (a) scars, lasting tissue damage, disfigurement; (b) a 3rd degree burn; (c) poisoning; or (d) loss of consciousness.

<u>Pica</u> involves the repetitive and persistent ingestion of inedible items (i.e., items that should not be eaten) such as bark, bugs, cigarette butts, clothing, coins, dirt, food dropped on the floor or ground, grass, leaves, paint chips, pet hair, etc.

☐Never ☐ Monthly ☐Weekly ☐Daily ☐Hourly ☐Over 5 per Hour ☐Over 10 per Hour

☐Level 1 = <u>not</u> involving any of the following: (a) solid items larger than 1/2 inch in diameter (e.g., coins, large buttons), (b) sharp items (e.g., pins, staples), (c) contaminated items (e.g., items from garbage can or ash tray, paint chips), or (d) toxic or poisonous items (e.g., medicines, glue).

☐Level 2 = involving (a) solid items larger than 1/2 inch in diameter (e.g., coins, large buttons), but <u>not</u> sharp, contaminated, or toxic or poisonous items.

☐Level 3 = involving sharp, contaminated, or toxic or poisonous items, but <u>not</u> requiring emergency medical attention (e.g., called physician for advice).

☐Level 4 = involving sharp, contaminated, or toxic or poisonous items and requiring emergency medical attention.

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, telephone)
Occupational Therapy			
Physical Therapy			
Speech			
Early Intervention			
Others: (please list)			

Preferences

Please list some of your child's favorite things.

Foods:____

Tangible Items:____________________________________

Activities:______________________________________