Harrisonburg-Rockingham CSB
Children's Services

Thank you for expressing an interest in receiving mental health services from the Harrisonburg-Rockingham CSB.

Please complete the following enclosed forms:

1) Intake Initial Information
2) Request for Service
3) Medical History

Please return the completed forms to:

Harrisonburg-Rockingham CSB
Attn: Same Day Access
1241 North Main St.
Harrisonburg, Virginia 22802

Children's intakes are held on Tuesdays from 8:30am-2:30pm and Thursdays 8:00am-2:30pm. An intake appointment typically takes 2-2.5 hours. During this appointment, your child will be assessed for the following services: outpatient therapy, medication management and case management services. Services are voluntary and we encourage your involvement in identifying the most appropriate services for your child and your family.

A legal guardian and the child need to be present during the intake process. If there are circumstances that prohibit this from occurring, please notify staff when you are scheduling the appointment. A consent form and a release of information need to be completed prior to the intake appointment for any child who will not be accompanied by a legal guardian.

If you need additional information or have any questions, please contact us at 540-434-1941.

Request for Service-Child

Child's Name_____ **Date of Birth**_____

Insurance Information:

Does your child have any type of **Medicaid**? ___YES ___NO **Medicare**? ___YES ___NO

Other health insurance? ___YES ___NO If so, what kind? _____

Name of insured: _____ Relationship: _____

Group #:_____ Policy #: _____

Employer of insured: _____

Information about your Request:

Did someone refer you to services? If YES, who?_____

What is the main problem your child needs help with:_____

Has your child had mental health or substance abuse treatment in the past? ___YES ___NO

If so, where and when? _____

Has your child come to the McNulty Center/HRCSB before? ___YES ___NO If **YES**, when? _____

_____

Is your child currently taking any medication? ___YES ___NO If **YES**, please list:

MEDICATION	DOSAGE	START DATE	PRESCRIBING DOCTOR

Does your child have any allergies to medications or foods? __YES __NO If **YES**, please list:

Medication, food, etc.	Severe? YES or NO	Reaction

Has your child ever used alcohol or drugs? __YES __NO If **YES** please list:

Type	How often?	How much?	Date of last use	Method of use

(continued on back)

Information about Your Child:

Please put a **check** next to the items that are of concern to you.

Behavior problems:

_____ Hyperactivity, trouble concentrating, or being easily distracted
_____ Arguing or disobeying rules at school or home, lying, stealing
_____ Outbursts of anger
_____ Other (please describe)_____

Mood Problems:

_____ Feeling sad or depressed
_____ Feeling nervous or anxious
_____ Mood swings, irritability
_____ Emotional issues related to past trauma or abuse

Relationship Problems:

_____ Conflict with important others
_____ Feeling lonely or socially isolated
_____ Problems with classmates or teachers
_____ Relationship loss or death

Substance Abuse Issues:

_____ Using alcohol or drugs
_____ Someone else thinks your child may have a problem with alcohol or drugs
_____ Your child needs to start an alcohol/drug program

Safety Problems:

_____ Hearing voices, seeing things, unusual thoughts If so, when_____
_____ Self harm or suicide attempt If so, when_____
_____ Thoughts of suicide or homicide If so, when_____
_____ Physical aggression (hitting, kicking, pushing, etc.) If so, when_____
_____Other dangerous or unhealthy life situation (please describe)_____

Daily Life Problems:

_____ Financial stress
_____ Housing problems
_____ Family conflict or domestic violence

Signature:_____ Date:_____

Medical History Form-Child

To be completed by the Guardian or Legal Authorized Representative

Date: _____

Child's Name : _____ **DOB:**_____

Does your child have a family doctor or pediatrician? ____ YES ____NO

If Yes, please list name and practice: _____

_____

Does your child see any other doctor or medical provider? ____ YES ____NO

If Yes , please list name and specialty:_____

_____

Does your child have any current or recent physical complaints? ____ YES ____NO

If Yes, please describe: _____

_____

Does your child have any Chronic Conditions such as Diabetes, Hypertension, Hepatitis C, etc…?

____ YES ____NO If Yes, please list_____

_____

Has your child had any past serious illnesses; serious injuries; or hospitalizations? ____ YES ____NO

If Yes, please describe:_____

_____

Has your child ever been around, or had symptoms of TB such as fever of long duration, unexplained weight loss, a bad cough lasting over two weeks or coughing up blood? ____ YES ____NO

Has your child ever had a positive TB skin test ? ____ YES ____NO

(continued on back)

Does your child have any communicable diseases? ____ YES ____NO

If yes, please list:_____

Does your child have any handicaps or restrictions on physical activities? ____ YES ____NO

If Yes, explain: _____

_____

Does your child have any significant communication problems? ____ YES ____NO

If Yes, please explain:_____

_____

Do the parents have any serious illnesses or chronic conditions? __YES __ NO

If yes, describe: _____

Do siblings have any serious illnesses or chronic conditions? __YES __ NO

If yes, describe: _____

Does anyone else in the household have any serious illnesses or chronic conditions? __YES __ NO

If yes, describe: _____

Does your child have any sexual health or reproductive history related to your request for services?

___ YES ___NO If Yes, please describe_____

_____

Signature of Parent or Guardian_____ Date_____

Reviewed by:

Signature of HRCSB Staff_____Date_____

Intake Initial Information - Children

Identifying Information

Child's Name: _____ Former Name_____
First Middle Last

Street Address:_____

City/Town_____ State:_____ Zip:_____

Date of Birth: _____ SSN:_____

Sex: (circle) Male / Female

If your child is seeking substance use services, is she currently pregnant? ___Yes ____No

Contact Information

Name of Parent(s) _____

Cell Phone: _____ Ok to call (circle) Yes No

Would you like to receive Text Appointment Reminders* (circle) Yes No
***English only/Standard Text Messaging Rates Apply**

Cell Carrier (circle): Alltel AT&T/Cingular Boost Mobile Cricket/AIO Wireless Nextel Sprint Straight Talk (AT&T) Straight Talk (Verizon) T-Mobile US Cellular Verizon Virgin Mobile Other: _____

Home Phone: _____ OK to call (circle) Yes No
Work/Other Phone: _____ OK to call (circle) Yes No
E-mail Address: _____ OK to e-mail (circle) Yes No

Name of legal guardian (if not parent)_____Relationship_____

Phone: _____ Ok to call (circle) Yes No

Name and address of person to contact in case of emergency:

_____
Name Address

_____
Phone Relationship

(Continued on back)

Name of School: _____ **Grade:** _____

Demographic Information

Please check the most appropriate choice for the following:

Race

____ Alaskan Native
____ American Indian
____ American Indian or Alaskan Native & White
____ American Indian or Alaskan Native & Black or African American
____ Asian
____ Asian and White
____ Black or African American
____ Black or African American & White
____ White
____ Other / Hispanic
____ Other Multi-Race
____ Native Hawaiian or Pacific Islander

Hispanic Origin

____ Puerto Rican
____ Mexican
____ Cuban
____ Other Hispanic
____ Not of Hispanic Origin
____ Hispanic – Specific origin not identified

Legal Status

____ Voluntary (referred)
____ Treatment Ordered:
    ____ Condition of probation
    ____ Condition of parole
    ____ Condition of diversion
    ____ Conditional Release (NGRI)
____ Involuntary Civil (MOT, Competency exams)

Referred by

____ Self
____ Family or Friend
____ Developmental Service Provider
____ School
____ Employer/EAP
____ ASAP or DUI Program
____ Police or Sheriff
____ Local Correctional Facility
____ State Correctional Facility
____ Probation
____ Parole
____ Other Community Referral
____ Private Hospital
____ Private Physician
____ Private MH Outpatient Provider
____ State MH Outpatient Provider
____ State Hospital
____ State Training Center
____ Substance Abuse Provider
____ Court
____ Health Department
____ Other CSB
____ Department of Rehabilitative Services
____ Department of Social Services -TANF
____ Department of Social Services – non TANF
____ Department of Juvenile Justice

Signature:_____ **Date:**_____