SANFORD HEALTH
Behavioral Health

- 722 15th Street NW, PO Box 640 • Bemidji, MN 56619-0640 (218) 751-3280 office, (218) 751-3298 fax
- Headwaters ACT Team: 408 Beltrami Ave NW, #2 (218) 444-4429 office, (218) 444-5491 fax
- 109 S. Grove Ave. Ste. 1 • Park Rapids, MN 56470 (218) 732-7266 office, (218) 237-8276 fax

Client #_____

Child Service Application

Name of Child: _____ Date:_____

Child's former name if applicable:_____ Sex: ☐ Male ☐ Female

SSN:_____ Date of Birth:_____ Age:_____

Name of person completing form:_____ Relationship to Child:_____

Who has current legal guardianship of child? (if different than parent):_____

Present address:_____ City:_____ State:_____ Zip:_____

County of residence_____Home Phone:_____ Work Phone:_____ Cell Phone:_____

(Completion of this section is optional) Child's Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian/Pacific ☐ Multi-racial
☐ Native American (Enrolled Tribal Member ☐ Yes ☐ No, where_____) ☐ Other_____

Who referred this child to Sanford Health Behavioral Health Center?_____

PRESENT PLACEMENT INFORMATION

Child Currently Lives:

- ☐ At home with family
- ☐ At a relative's home (name and relationship of custodial adults in this home):

  _____
- ☐ In a foster home (name of foster parents)_____
- ☐ At a group home or residential facility (name of facility)_____
- ☐ Other (please explain)_____

  Length of time child has been at current placement?:_____

FAMILY HISTORY

Biological Mother's name:_____Age:_____Lives with child?☐ Yes ☐ No
Has the mother or any of the mother's relatives experienced problems similar to those currently experienced by the child?
☐ Yes ☐ No. If yes, please Explain:_____

_____

Biological Father's Name:_____Age:_____Lives with child?☐ Yes ☐ No
Has the father or any of the father's relatives experienced problems similar to those currently experienced by the child?
☐ Yes ☐ No. If yes, please Explain:_____

_____

MARITAL

Are the biological parents of the child ☐ Married ☐ Separated ☐ Divorced ☐ Living together
☐ Never were together ☐ Widowed ☐ Other_____

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Are the biological parents now remarried or living with a significant other? ☐ Yes ☐ No
Please describe any abuse, chemical dependency or legal difficulties in the child's immediate relatives:_____

_____

_____

Other people residing in the same household with child:

Name	Age	Occupation	Relationship to Child

EARLY CHILDHOOD DEVELOPMENTAL HISTORY

Was the pregnancy: a) planned? ☐ Yes ☐ No
b) welcomed? ☐ Yes ☐ No
c) stressful? ☐ Yes ☐ No

At any time during the pregnancy did the mother use:

a) prescribed medications ☐ Yes ☐ No If yes, how much?_____
b) recreational drugs ☐ Yes ☐ No If yes, how much?_____
c) alcohol ☐ Yes ☐ No If yes, how much?_____
d) tobacco ☐ Yes ☐ No If yes, how much?_____

Were there any medical concerns or other issues during this pregnancy regarding mother and/or baby?

_____

_____

At the time of birth did the baby have?

☐ trouble breathing ☐ Yellow jaundice ☐ blood transfusion
☐ resuscitation ☐ jitteriness ☐ physical injuries
☐ twin ☐ seizures/fits ☐ trouble sucking
☐ birth defects ☐ cord around neck ☐ intensive care
☐ fevers or low temperature

Is your child adopted?_____ Does child know?_____ If not, do you intend to tell the child?_____
At what age was the child placed in your home?_____ At what age when adopted?_____

Do you have any concerns about your child's motor or muscle development: ☐ Yes ☐ No
If so, please describe…

_____

_____

Do you have any concerns regarding your child's language development: ☐ Yes ☐ No
If so, please describe…

_____

_____

SCHOOL/WORK

Level of Education:_____ Grade: _____ Current School: _____
Class Placement: ☐ Mainstream ☐ Special Class (where)_____

Teacher or Advisor's name:_____ IEP in place? ☐ Yes ☐ No

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Does the child have any learning disabilities? ☐ Yes ☐ No
If yes, please describe: _____

Please list all the schools the child has attended:

Name of School	Address of School	Grade(s) Atttended

MEDICAL

Who is your child's medical doctor? _____

When was your child's last physical examination? _____ Results: _____

Are there any medical problems we should be aware of and/or that may be impacting your child's mental health?
☐ Yes ☐ No If yes, please explain: _____

Has your child been to the Emergency Room to visit in the last year? ☐ Yes ☐ No
If yes, what condition(s)? _____

Has there been any history of head trauma, seizures, or loss of consciousness? ☐ Yes ☐ No
If yes, please explain: _____

Has your child had past suicide attempts/thoughts? *(Please describe date and method.)*
How: _____

When: _____

Is your child allergic to or ever had an adverse reaction to any medications? ☐ Yes ☐ No

If yes, please explain: _____

Does your child have any other allergies? ☐ Yes ☐ No

For example: foods, airborne _____

Is your child pregnant? ☐ Yes ☐ No

Has there been mental health services involved with this child before? ☐ Yes ☐ No
If yes explain: _____

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Has your child ever been treated/experienced any of the following?

- ☐ Abnormal movements
- ☐ Birth or developmental problems
- ☐ Alcohol Abuse ☐ Drug Abuse
- ☐ ADHD/hyperactivity
- ☐ Anxiety ☐ Fears
- ☐ Failure to complete tasks
- ☐ Depression
- ☐ Eating problems ☐ too much ☐ too little
- ☐ Head injury/concussion
- ☐ Other serious injury or accident
- ☐ Seizure
- ☐ Suspension/expulsion/truancy – school
- ☐ Yelling/swearing
- ☐ Hearing voices, seeing something others didn't
- ☐ Sleep disturbance or difficulty
- ☐ Weight loss/gain
- ☐ Other _____
- ☐ Hospitalization
- ☐ Chronic pain
- ☐ Irritable
- ☐ Headaches, migraines
- ☐ Fights/stealing/lying
- ☐ Fear of germs
- ☐ Legal problems
- ☐ Destroying property
- ☐ Bedwetting/Incontinence
- ☐ Menses
- ☐ Decreased interest in friends/activities
- ☐ Vision problems
- ☐ Hearing problems ☐ Speech
- ☐ Setting fires
- ☐ Sexually transmitted disease

If illness is indicated, please comment on length and duration of problem: _____

_____

CURRENT MEDICATION	DOSAGE	PRESCRIBED BY

PAST MEDICATIONS: _____

Do you take vitamins, herbal medications, diet supplements, or other over-the-counter medications? ☐ Yes ☐ No

If yes, what type, how much, how long? _____

Does your child use tobacco? ☐ Yes ☐ No How much:_____ How often?_____

Does your child use caffeine? ☐ Yes ☐ No How much:_____ How often?_____

LEGAL

Is your child currently on probation? ☐ Yes ☐ No Probation Officer:_____

Are there any current or pending legal actions against the child? ☐ Yes ☐ No
If yes explain:_____

Is the County Social Services involved with this child or family? ☐ Yes ☐ No
If yes explain:_____

Is your child/family currently involved in any custody disputes? ☐ Yes ☐ No
If yes explain:_____

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PROBLEM DESCRIPTION:

Please describe the problem(s) that brings the child to Sanford Health Behavioral Health Center at this time:_____

_____

_____

_____

What would you like to see change by coming here?_____

_____

_____

Symptom	Frequently	Sometimes	Rarely	Never
Does your child				
Have trouble paying attention				
Make careless mistakes				
Not seem to listen when spoken directly to				
Have difficulty following through on instructions				
Struggle to be organized				
Fail to finish tasks or assignments				
Give up when he/she becomes frustrated				
Have trouble concentrating for long periods of time				
Tend to lose many of his/her belongings				
Becomes easily distracted by things going on around him/her				
Seem to be forgetful				
Fidget and squirm excessively				
Seem to have difficulty staying seated				
Seem to be driven by a motor				
Blurt out answers				
Run around excessively in inappropriate situations				
Have difficulty waiting his/her turn				
Have difficulty with peer relationships				
Interrupts others (e.g. butt into conversations or games)				

Would you consider your child to be depressed? ☐ Yes ☐ No
If yes, what are your concerns?

_____

_____

Symptom	Frequently	Sometimes	Rarely	Never
Does your child				
Seem to have diminished interest in things they usually enjoy				
Have abnormal changes in his/her weight				
Demonstrate concerns regarding his/her eating habits				
Have low energy or seem fatigued				
Have feelings of worthlessness or hopelessness				
Have difficulty making decisions				
Have recurrent thoughts of death				
Think about suicide				
Ever hurt himself or herself on purpose				
Have difficulty falling or staying asleep				

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Would you consider your child to be anxious or worried? ☐ Yes ☐ No
If yes, what are your concerns? _____
_____

Symptom	Frequently	Sometimes	Rarely	Never
Does your child:				
Have difficulty when they are separated from the family or home				
Have excessive fears about bad things happening				
Report physical symptoms when they are trying to avoid something				
Have *nightmares* regarding these events				
Experience reminders of the event that may trigger stress				
Try to avoid memories, conversations or activities associated with this event				
Complain of seeing or hearing things other people don't see or hear				
Find it difficult to control their worry				
Restless, feeling keyed up, or on edge				
Sleep disturbances				

Has your child ever experienced anything that has been difficult for him/her to cope with? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

Symptom	Frequently	Sometimes	Rarely	Never
Does your child				
Lose his/her temper				
Argue with adults				
Refuse to follow the rules of adults				
Seem to deliberately annoy people				
Blame other people for his/her misbehavior or mistakes				
Seem touchy or easily annoyed by others				
Seem to be feeling resentful or angry				

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Symptom	Frequently	Sometimes	Rarely	Never
Does your child				
Bully, threaten, or intimidate other people				
Physically cruel to animals or people				
Seem to experience truancy from school				
Stay out at night despite your rules				
Run away from home				
Force people into sexual activity				
Engage in fire setting behavior				
Destroy other people's property				
Lie to get things from other people or avoid responsibility				

Symptom	Frequently	Sometimes	Rarely	Never
My child:				
Has difficulty with eye contact, facial expression, and/or body language				
Struggles to develop peer relations appropriate to developmental level				
Lacks shared enjoyment, interest, or achievement with others (doesn't show, bring, or point out objects of interest to others)				
Lacks social or emotional exchange with others				
Has abnormal level of focus or intensity regarding stereotyped or restricted patterns of interest				
Has inflexible routines or rituals				
Repeats physical movements (hand flapping, finger twisting)				
Has persistent preoccupation with part of objects				

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Acceptance of Financial Responsibility

Client Name:_____ DOB:_____

PLEASE INDICATE HOW THE SERVICES REQUESTED ARE TO BE PAID:

☐ **Bill insurance carrier or other as indicated:**
(Charges for services requested are to be billed to the following sources)

☐ Insurance (primary) Carrier_____ Other Pay Source_____
Group #_____
Policy #_____ Amount Covered_____

☐ Insurance (secondary) Carrier_____ Client Co-pay (if applicable)_____
Group #_____
Policy #_____

☐ Medical Assistance MA#_____

☐ Consolidated
Date of Funding Assessment/Assessors Name_____

☐ BASC ☐ Prime West ☐ ISD #31 School Grant ☐ Private Pay

I understand that if coverage has lapsed, if the services requested are not covered by the plan, if plan caps have been exceeded, or if the services are denied by the carrier but I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize SANFORD HEALTH BEHAVIORAL HEALTH to furnish information to the payment sources concerning my illness and treatments and hereby assign to SANFORD HEALTH BEHAVIORAL HEALTH all payments for services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by Policy Holder or Representative. See the attached Fee Schedule and Payment Contract for additional terms. I understand that my insurance carrier or other third party payer may inform the "subscriber" of any services billed to the payer.

As a client of Upper Mississippi Mental Health Center, I agree to the following statements with regard to payment for services:

- Clients are required to pay for services received. A client may choose to bill third party insurance including Medical Assistance and Medicare. In the event that the third party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
- If Clients choose to use insurance, they agree to provide insurance information to SANFORD HEALTH BEHAVIORAL HEALTH and agree to assist in billing for insurance reimbursement.
- Self-pay clients are expected to pay for services at that time they are received. A 5% discount is offered for full cash payment at the time of service. Billing arrangements accepted by SANFORD HEALTH BEHAVIORAL HEALTH other than full payment at the time of service are listed below under SPECIAL CONDITIONS.
- If a billing arrangement is made, a minimum payment of $25 per month or 10% of the total bill, whichever is higher, will be expected.
- Interest in the amount of 1.5% of the balance will be charged on accounts which are 60 days in arrears.
- In the event of non-payment, the bill will be sent to collections.
- SANFORD HEALTH BEHAVIORAL HEALTH reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.

The client agrees that if circumstances such as income, number of dependents, insurance or eligibility or various programs change, the client will notify SANFORD HEALTH BEHAVIORAL HEALTH. SPECIAL CONDITIONS: _____

Client Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

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