Patient Name:_____

Medical Record Number:_____

Addressograph

GUNDERSEN HEALTH SYSTEM®

La Crosse, WI 54601

BEHAVIORAL HEALTH CHILD INTAKE SCREENING FORM

1. Who referred you to our clinic? _____
2. What school do you attend? _____
   What grade are you in? _____
3. Do you wish others to be involved in your care? If so, please give name(s) and relationship to you.

   _____

   _____
4. Please list family members/others that will be involved in your care: _____

   _____
5. Please describe the reason you are seeking services: _____

   _____

   _____
6. Please list any prior mental health treatment: _____

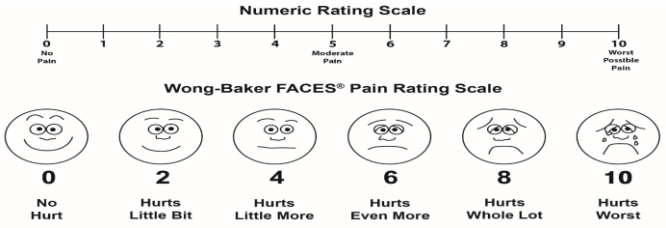
   _____

   _____

Please check any of the following that apply to you (or your child):

- ☐ Family problems
- ☐ Problems with friends
- ☐ School attendance problems
- ☐ Learning problems
- ☐ Physical abuse
- ☐ Emotional abuse
- ☐ Behavior Problems
- ☐ Thoughts of hurting yourself or others
- ☐ Past suicide attempt(s)
- ☐ Problems controlling anger
- ☐ Problems with appetite
- ☐ Weight Loss or Gain
- ☐ Changes in eating habits
- ☐ Growth or development problems
- ☐ Sexual Abuse
- ☐ Legal Issues
- ☐ Thoughts of Suicide
- ☐ Feelings of hopelessness
- ☐ Problems with irritability
- ☐ Problems with falling or staying asleep

Physical pain: ☐ Yes ☐ No If yes, please rate:



Medical History:

Primary Care Physician: _____

Current Medications: _____

_____

Are you currently using tobacco? ☐ Yes ☐ No If yes, do you desire help with quitting? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____