5060 Allatoona GTWY,
Acworth, GA 30101
(470) 507-3067
info@healthstarbehavioral.com

HEALTHSTAR BEHAVIORAL HEALTH SERVICES

NEW INTAKE FORM - CHILDREN / ADOLESCENTS

PERSONAL INFORMATION:

Patient Information:

- Full Name: _____
- Date of Birth: _____
- Age: _____
- Gender: _____
- School Grade: _____
- School Name: _____
- Parent/Guardian Name: _____
- Address: _____
  _____
- City: _____
- State: _____
- Zip Code: _____
- Phone Number: _____
- Email Address: _____

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EMERGENCY CONTACT:

Emergency Contact:

- Full Name: _____
- Relationship to Patient: _____
- Phone Number: _____

INSURANCE INFORMATION:

Insurance Information:

- Insurance Provider: _____
- Policy/Member ID: _____
- Group Number:
- Primary Policy Holder (if different): _____

MEDICAL HISTORY:

Medical History:

- Primary Care Physician: _____
- Any Chronic Health Conditions (e.g., asthma, allergies): _____
  _____
- Current Medications (prescription, over-the-counter, supplements): _____
  _____
- Allergies (food, medication, environmental): _____
  _____
- Previous Surgeries or Hospitalizations: _____
  _____

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Mental Health History:

- Reason for Seeking Treatment: _____
- Previous Mental Health Diagnoses (if any): _____

  _____
- Previous Mental Health Treatments (therapy, medication): _____

  _____
- Any History of Trauma or Abuse: _____

Current Symptoms:

- Description of Current Symptoms or Concerns: _____

  _____
- Onset and Duration of Symptoms: _____
- Triggers or Stressors: _____

  _____
- Impact on Daily Functioning (school, home, social activities): _____

  _____

SCHOOL & SOCIAL HISTORY:

School and Social History:

- School Performance (academic, behavioral): _____

  _____
- Peer Relationships: _____
- Extracurricular Activities: _____

  _____
- Family Dynamics: _____

  _____

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ADDITIONAL INFORMATION:

Additional Information:

- Preferred Language: _____
- Cultural or Religious Considerations: _____
- Any Additional Information or Concerns: _____

  _____

  _____

CONSENT AND AUTHORIZATION:

Consent and Authorization:

- I authorize the release of information to my insurance company for billing purposes.
- I authorize the exchange of information between my child's primary care physician and mental health provider.
- Signature of Parent/Guardian: _____
- Date: _____