# [FIRST POINT](https://www.firstpointurgentcare.org/%22%20%5Ct%20%22_self) [URGENT CARE INC.](https://www.firstpointurgentcare.org/)

## Immigration Screening Form 16-17 years Old

## Patient’s First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Preferred Name (Alias/Nickname) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Place of Birth (City/Town/Village) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Street Address Line 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## City State / Province/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Alien Registration Number(A-number) if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Race: Asian Black White Prefer not to disclose Other

## Ethnicity: Not Hispanic/Latino Hispanic/Latino Prefer not to disclose Other

## Caregiver completing this form:

## Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Street Address Line 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## City State / Province/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Work Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Primary insurance provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Claims Address Or EDI/Payor ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Policy ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Who is the policy holder? Self Other Person

## If policy holder is separate person, please provide the information below:

## Name: First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Date of birth of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Patient relationship to policy holder (circle one): Self/Spouse/Child/Other

## I authorize First Point Urgent Care to correspond with me with email that is NOT encrypted and not HIPAA Compliant (circle one) True False

## Please initial below:

##  \_\_\_\_\_\_\_\_ I have been given the opportunity to read the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## \_\_\_\_\_\_\_\_\_ I have read, understand, and agree to the Payment Policy outlined by First Point Urgent Care (FPUC).

## Sharing of Medical Information.

## *\*\*\*Note: If the following information is left blank, we cannot share medical information with any person.*

## I authorize First Point Urgent Care to discuss my child’s medical health information with:

## First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Are you, or is there a chance you may be pregnant?\*

## \_\_\_I am pregnant

## \_\_\_I am not pregnant

## \_\_\_I am unsure if I am pregnant

## \_\_\_Not applicable

## Past Medical History (required):

## History of tuberculosis vaccine: Yes No

## History of latent tuberculosis: Yes No

## History of tuberculosis treatment: Yes No

## History of positive tuberculosis skin test: Yes No

## History of syphilis: Yes No

## History of gonorrhea: Yes No

## History of substance abuse: Yes No

## History of behavioral health medication: Yes No

## History of behavioral health admission: Yes No

## History of behavioral health counseling: Yes No

## History of Hansen's (skin) disease: Yes No

## History of Leprosy: Yes No

## If "yes" to any health history questions above, please provide date(s):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##  Surgical History (Type of Surgery/Reason and Year):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Medication Allergies (Name of Medication/Product and Reaction):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Medications/Supplements (Name, Strength and Frequency):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Other Providers you see (Name, Phone# and Specialty):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Current Primary Care Physician (Name and Phone#):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Caregiver to answer the following questions.

## Please mark under the option that best fits your child.

## Complains of aches and pains:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Spends more time alone:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Tires easily, has little energy:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Has trouble with teacher:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Less interested in school:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Acts as if driven by a motor:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Daydreams too much:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Distracted easily:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Is afraid of new situations:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Feels sad, unhappy:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Is irritable, angry:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Feels hopeless:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Has trouble concentrating:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Less interested in friends:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Fights with other children:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Absent from school:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## School grades dropping:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Is down on him or herself

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Visits the doctor with doctor finding nothing wrong:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Has trouble sleeping:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Worries a lot:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Wants to be with you more than before:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Feels he or she is bad:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Takes unnecessary risks:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Gets hurt frequently:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Seems to be having less fun:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Acts younger than children his or her age:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Does not listen to rules:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Does not show feelings:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Does not understand other people's feeling:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Teases others:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Blames others for his or her troubles:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Takes things that do not belong to him or her:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Refuses to share:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Does your child have any emotional or behavioral problems for which she or he needs help with?

## \_\_\_ Yes

## \_\_\_No

## Are there any services that you would like your child to receive for these problems?

## \_\_\_ Yes

## \_\_\_No

## If yes, what services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Guardian Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## CHILD to answer the following questions:

## Complains of aches and pains:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Spends more time alone:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Tires easily, has little energy:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Have trouble with teachers:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Less interested in school:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Acts as if driven by a motor:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Daydreams too much:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Distracted easily:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Are afraid of new situations:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Feels sad, unhappy:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Are irritable, angry:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Feel hopeless:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Have trouble concentrating:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Less interested in friends:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Fight with other children:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Absent from school:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## School grades dropping:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Are down on yourself:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Visits the doctor with doctor finding nothing wrong:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Have trouble sleeping:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Worry a lot:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Want to be with your parents more than before:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Feel like you are bad kid:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Take unnecessary risks:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Get hurt frequently:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Seem to be having less fun:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Act younger than children your age:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Do not listen to rules:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Do not show feelings:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Do not understand other people's feeling:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Tease others:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Blame others for your troubles:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Take things that do not belong to you:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Refuse to share:

## \_\_\_ Never

## \_\_\_Sometimes

## \_\_\_Often

## Do you have any emotional or behavioral problems you need help with?

## \_\_\_ Yes

## \_\_\_No

## Are there any services that you would like to receive for these problems?

## \_\_\_ Yes

## \_\_\_No

## If yes, what services? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Patient Initials\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_