|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Child/Adolescent Information | | | | | |
| **Name** | **DOB** | | | **Gender: M or F F** | **SS#** |
| **Address** | **City** | | | **County** | **Zip** |
| **Parent/Guardian Signature** | **Print Parent/Guardian’s Name** | | | **Primary Language: (Circle One)**  **English Spanish Other** | |
| **Home Telephone Number** | **Alternative Contact Number** | | | | |
| **Guardian (please select one):**  **🞎 Biological parent 🞎 Biological Grandparent**  **🞎 Biological Aunt/Uncle 🞎 Biological adult sibling** | **🞎 CPS**  **🞎 Foster Parent** | | **Guardian’s Marital Status (please select one):**  **🞎 Single 🞎 Married 🞎 Divorced 🞎 Separated** | | |
| **Reason for Non-Crisis Referral:** | **Grade:** | | **School Name:** | | |
| ***Insurance Information*** | | | | | |
| **Type of Insurance: (Please Circle One)**    **PLEASE NOTE**  At this time we are only accepting Medicaid or No Insurance  (We are unable to accept CHIP or Private Insurance)  **Medicaid No Insurance**  **Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**    **Medicaid ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **For Mental Health Emergencies, you may call our Crisis Unit:**  **N**europsychiatric Center (NPC)  at (713) 970-3800 (open 24 hours a day) | | | | | |
| ***Problem Areas*** | | | | | |
| * Withdrawn / Depressed Behavior * Sleeping Difficulties * Eating Problems * Worrying /Anxious * Poor Attention Span * Impulsive * Poor School Performance * Easily Angered or Irritable * Stealing, Lying, Cheating (Circle Applicable) * Disrespectful or Argumentative | | * Disrespectful / Argumentative (Circle Applicable) * Substance Abuse * Self-Destructive * Fire Setting / Property Destruction (Circle Applicable) * Hallucinations / Delusions (Circle Applicable) * Violence or Cruelty to Animals * Verbally / Physically Aggressive (Circle Applicable) * Strained Family Relationships * Deteriorating Classroom Behavior * Other (explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ***Requesting Screening for the Following:*** | | | | | |
| * Information & Referral 🞎 Assessment | | * Individual or Family Counseling | | | |

**Referral Source Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_**

***2/28/2018 NF***