Behavior Management Systems

BMS Cares

Intake Screening Form- Adolescent

FIRST DATE OF SERVICE: _____ **STAFF ASSIGNED:** _____

1st CHILD'S NAME _____ DOB: _____

SCHOOL: _____ AVAILABILITY: _____

PRESENTING PROBLEM: _____

_____

CHILD'S SSN: _____ MALE/ FEMALE/ NONBINARY

○ SELF PAY/BLOCK ELIGIBLE ○ T19/MEDICAID: _____ AID___ELIG _____

2ND CHILD'S NAME _____ DOB: _____

SCHOOL: _____ AVAILABILITY: _____

PRESENTING PROBLEM: _____

_____

CHILD'S SSN: _____ MALE/ FEMALE/ NONBINARY

○ SELF PAY/BLOCK ELIGIBLE ○ T19/MEDICAID: _____ AID___ELIG _____

3RD CHILD'S NAME _____ DOB: _____

SCHOOL: _____ AVAILABILITY: _____

PRESENTING PROBLEM: _____

_____

CHILD'S SSN: _____ MALE/ FEMALE/ NONBINARY

○ SELF PAY/BLOCK ELIGIBLE ○ T19/MEDICAID: _____ AID___ELIG _____

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN ADDRESS: _____

PARENT/GUARDIAN PHONE NUMBER: _____

RELATIONSHIP TO CLIENT: _____

GROSS HOUSEHOLD INCOME (MONTHLY OR YEARLY): _____

NUMBER OF PEOPLE IN YOUR HOUSEHOLD: _____

CHILDCARE EXPENSES _____ **MEDICATION EXPENSES** _____

INSURANCE PREMIUMS _____

***IF CLIENT HAS PRIVATE INSURANCE OR TRICARE**

O INSURANCE COMPANY: _____

POLICY HOLDER: _____ DOB: _____ SSN: _____

INSURANCE ID NUMBER: _____ GROUP NUMBER: _____

INSURANCE COMPANY ADDRESS ON BACK OF CARD: _____

_____

O TRICARE SPONSOR NAME: _____ SPONSOR DOB: _____

SPONSOR SSN OR BENEFIT ID NUMBER: _____ ACTIVE DUTY/RETIRED

DEMOGRAPHIC INFORMATION FOR CLIENT

HIGHEST GRADE CLIENT COMPLETED: _____ BIOLOGICAL MOM'S FIRST NAME: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

DID ANYONE REFER YOU: _____

Special Education:
____ No
____ Yes

English Proficiency
____ Full
____ Limited
____ Requires Assistance

Child Living Arrangement: (client 17 and under)
____ Both Parents
____ Single Parent
____ Foster Home
____ Other Relative
____ Parent/Step parent
____ Therapeutic Foster Care
____ Independent Living
____ Private Care Facility
____ Public Care Facility
____ Homeless
____ Other

Primary Race:
____ Alaska Native
____ American Indian
____ Asian
____ White
____ African American
____ Other

Ethnicity:
____ Puerto Rican
____ Cuban
____ Other Specific Hispanic
____ Hispanic – Origin not Specific
____ Not of Hispanic Origin

If Homeless:
____ Continuously for 1+ years
____ 4+ episodes in the past 3 years
____ Neither of the above

Referral Source:
____ Self/Family/Friend
____ DSS
____ Court/Attorney
____ Alcohol/Drug Provider
____ Medical Physician
____ Child/Daycare Provider
____ Indian Health Services
____ Public Health Services
____ School
____ Community Health
____ Residential
____ Dept. of Disability
____ Clergy
____ Hotline
____ Medical
____ Other

Releases of Information Needed: _____

_____