Behavioral Care Center of New Jersey, LLC
205 Ridgedale Avenue, Suite 101
Florham Park, NJ 07932
Phone: (973) 660-0700

Patient Information:

Name: _____

Date of Birth: _____ Age: _____ Sex: M_____ F_____

Address: _____

_____

Phone: Home _____
Cell _____
Email _____

Name of person who referred you: _____
Phone Number: _____

School Information:

Highest grade completed:_____

Family Information:
Please list all people who currently live with you:

Name	Relationship to You	Age

Mother's Occupation: _____

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Father's Occupation: _____

Parents are:
married/domestic partners____ divorced____ separated____ never married____

Have you ever experienced the death of or separation from family members or close friends?

_____
_____
_____

Have you ever experienced a traumatic or significantly upsetting event?

_____
_____
_____

Have any family members suffered from any of the following psychiatric problems? If yes, who? Was treatment sought?

Anxiety:	_____	Aggression:	_____
Depression:	_____	OCD	_____
Bipolar Disorder:	_____	Substance Use	_____
Panic Attacks:	_____	Other:	_____

Medical Information:

Are you now or have you ever had sleep problems? Y N
If so please explain:

_____
_____

Do you have any medical problems or have you ever been in the hospital?

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Y N If so please explain:

_____
_____
_____

Please list any current medications that you are taking:

_____
_____

Have you ever received mental health treatment? Y N
If so please explain when the treatment occurred, the reason for the treatment, and what type of treatment was received (i.e. individual therapy, family therapy, group therapy, hospitalization):

_____
_____
_____

Are your currently, or have you ever been prescribed psychotropic medication? Y N .
If so please list all medications, doses, and when they were taken: _____

_____
_____

Please describe why you are seeking treatment:

_____
_____
_____
_____
_____

When did these difficulties begin? Did any specific event occur prior to onset?

_____
_____
_____

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Please check off any of the following problems with which you are currently struggling:

_____ sad/depressed mood
_____ anxious
_____ Panic Attacks
_____ Angry Outbursts
_____ Withdrawn
_____ Fatigue
_____ Decreased appetite
_____Increased appetite
_____ Excessive weight gain/loss

_____ Increased sleep
_____ Decreased sleep
_____ Nightmares
_____ Drug Use
_____ Poor attention
_____ hyperactivity
_____ Stealing
_____ Alcohol/drug use
_____ Difficulty sleeping through the night

_____ Purging
_____Physical Aggression
_____ Truancy
_____ Suicidal thoughts
_____ Suicide attempt
_____ Self injury (i.e. cutting)
_____ Poor family relationships
_____ Poor peer relationships
_____ inappropriate sexual behavior