



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 you 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?

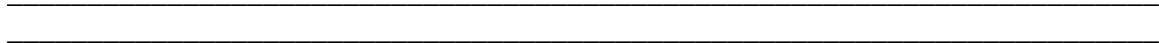


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Please check off any of the following problems with which you are currently struggling:

- | | | |
|---|--|--|
| <input type="checkbox"/> sad/depressed mood | <input type="checkbox"/> Increased sleep | <input type="checkbox"/> Purging |
| <input type="checkbox"/> anxious | <input type="checkbox"/> Decreased sleep | <input type="checkbox"/> Physical Aggression |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Angry Outbursts | <input type="checkbox"/> Drug Use | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Poor attention | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> hyperactivity | <input type="checkbox"/> Self injury (i.e. cutting) |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Stealing | <input type="checkbox"/> Poor family relationships |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Alcohol/drug use | <input type="checkbox"/> Poor peer relationships |
| <input type="checkbox"/> Excessive weight gain/loss | <input type="checkbox"/> Difficulty sleeping through the night | <input type="checkbox"/> inappropriate sexual behavior |