BEL CENTER LLC

BEHAVIOR AND EMOTIONAL LEARNING CENTER OF SOUTHERN VERMONT

# BEL Center Initial Intake Form

| | | | |
|---|---|---|---|
| Client Name: | | Todays Date: | |
| Client Date of Birth: | | Age: | |
| Person Completing this Form: | | | |
| Relationship to Client: | | | |

| **Address** | | | |
|---|---|---|---|
| Street Address: | | | |
| Town: | | State: | |
| Home Phone | | Cell Phone: | |
| Email: | | | |

*It is often convenient to use email to communicate regarding appointments and billing questions. We do not use email to communicate clinical information. If you do not want us to use email to send appointment reminders or to communicate about other non-clinical issues please check the box below.

☐ Please do not use email to contact me.

| **Secondary Address** ( if needed) | | | |
|---|---|---|---|
| Street Address: | | | |
| Town: | | State: | |
| Home Phone: | | Cell Phone: | |
| Email:* | | | |

☐ Please do not use email to contact me.

# Insurance Information

If you plan on paying for services without using insurance please check the box below. If your wish to use Insurance please be aware that we are required to submit a diagnosis to your insurance company. We will discuss this with you before we communicate anything to your insurance but we recognize that this can feel like a sensitive issue for many people and want to make sure help you make an informed decision.

☐ I plan on paying for services out of pocket.

| **Primary Insurance** | | | |
|---|---|---|---|
| Name of Insured: | | | |
| Relationship to Client: | | | |
| Insurance Company: | | | |
| Group Number: | | Member Id: | |
| Provider services Phone Number (On back of card): | | | |
| Copay Amount (We are considered a specialist): | | | |

| **Secondary Insurance** | | | |
|---|---|---|---|
| Name of Insured: | | | |
| Relationship to Client: | | | |
| Insurance Company: | | | |
| Group Number: | | Member Id: | |
| Provider services Phone Number (On back of card): | | | |
| Copay Amount (We are considered a specialist): | | | |

- Please read and sign our Fee Agreement, Consent to Provide Services and Notice of Privacy Practices form and submit these at the initial intake. Any questions regarding any of these forms can be answered at that time.

- We will need to make a copy of the insurance card at intake so please plan on having that available.

# Brief Clinical Screening

| **What brings you in for services at this time?** | |
|---|---|
| | |
| | |
| Have you ever received behavioral healthcare services in the past? | |
| | |
| Provider Name: | |
| Issues Addressed: | |

| **Education** | | | |
|---|---|---|---|
| School Name: | | Grade: | |
| Number of years at current school: | | | |
| Is client identified at school? ☐ 504 plan ☐ Eligible for Special education | | | |
| Please check any of the below that apply:<br>☐ Separation to school ☐ Academic performance issues<br>☐ Behavior problems ☐ Does not like school | | | |

| **Medical** | |
|---|---|
| Primary care physician: | |
| Office number: | |
| Allergies: | |
| Chronic Medical Conditions: | |

| **Current Daily Functioning:** | | | |
|---|---|---|---|
| Sleep: | Hours per Night: | Issues Falling asleep: ☐ | Staying asleep:☐ |
| Appetite: | ☐Excellent ☐Fair ☐Poor ☐Variable | | |
| Mood: | ☐Excellent ☐Fair ☐Poor ☐Variable | | |

| **Social Relationships:** *Please check the box that best represents current functioning* |
|---|
| Family: ☐ Excellent ☐ Good ☐Fair ☐Poor |
| Peers: ☐ Excellent ☐ Good ☐Fair ☐Poor |
| Adults outside the Family *(Teachers, caregivers, etc):* : |

| ☐ Excellent ☐ Good ☐Fair ☐Poor |
| --- |