DAYBREAK FACE SHEET
PATIENT INFORMATION

Name: _____ Preferred Name: _____

Sex: M / F Age: _____ Date of Birth: ____/____/____ Race/Ethnicity: _____

Patient phone #: _____ Patient email address: _____

Address: _____

Street City State Zip

School Patient is Currently Attending: _____ Grade: _____

Who Referred You Here? : _____

PARENT/GUARDIAN INFORMATION:

Name(s): _____ Phone #: _____ Email: _____

Address (if different from child) _____

Name(s): _____ Phone #: _____ Email: _____

Address (if different from child) _____

Emergency Contact Name and Phone#: _____

PRIMARY INSURANCE INFORMATION:

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Name of Insured: _____ Relationship to patient: _____

Employer: _____ Insured's Address: _____

Insured's SSN: _____-_____-_____ Policy#: _____ Group#: _____

SECONDARY INSURANCE INFORMATION:

Insurance Co.: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Name of Insured: _____ Relationship to patient: _____

Employer: _____ Insured's Address: _____

Insured's SSN: _____-_____-_____ Policy#: _____ Group#: _____

MEDICAL INFORMATION:

Allergies: _____

Current Medications, Dosages, and Prescribing MD: _____

_____

Pharmacy Name and Phone#: _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED, REGARDLESS OF INSURANCE COVERAGE OR OTHER THIRD PARTY LIABILITY.

_____ ____/____/____

SIGNATURE **DATE**

DAYBREAK
TREATMENT CENTER

BIO PYSCHOLOGICAL ASSESSEMT
PARENT REPORT

PART ONE
(REVISED 6/2019)

INSTRUCTIONS: Please answer all questions to the best of your ability. Some questions will not apply to you or your child, in those cases, please indicate by writing NA in the space provided. If needed, you may use the back to add additional information. **(PLEASE USE INK)**

Date: ___/___/___

PATIENT INFORMATION:

Child's Name: _____ Date of Birth: ___/___/___
Child's School: _____ Grade: _____
Name of person completing this form: _____
Relationship to Child: _____
Who referred child to Daybreak Treatment Center? _____

Tell us why you are seeking help for your child now? Have behaviors gotten worse? Are they engaging in behaviors that are harmful to them or to others?

_____
_____
_____
_____
_____
_____
_____

In the past 10 days, how severe/frequent have these concerns been for your child?

	Never	Rarely	Sometimes	Often	Every Day
Suicidal Thoughts or Actions	☐	☐	☐	☐	☐
Self-Harm Urges or Actions	☐	☐	☐	☐	☐
Depression/Moodiness	☐	☐	☐	☐	☐
Hyperactivity/Attention Span	☐	☐	☐	☐	☐
Anger Outbursts/Aggression	☐	☐	☐	☐	☐
Problems Concentrating	☐	☐	☐	☐	☐
Grades/School Work	☐	☐	☐	☐	☐
Behavior at School	☐	☐	☐	☐	☐
Alcohol or Drug Use	☐	☐	☐	☐	☐
Conflict with Family	☐	☐	☐	☐	☐
Conflict with Friends/Peers	☐	☐	☐	☐	☐
Self-Esteem	☐	☐	☐	☐	☐
Taking Responsibility	☐	☐	☐	☐	☐
Accepting Consequences	☐	☐	☐	☐	☐

Which of these areas are having the biggest effect on your child's overall functioning?

_____

_____

_____

When did these problems start?

_____

_____

_____

Are you aware of any events that may have caused these problems?

_____

_____

_____

Has your child ever talked about or attempted suicide? ☐ Yes ☐ No

Has your child ever hurt themselves intentionally? ☐ Yes ☐ No

Has your child ever attempted to run away? ☐ Yes ☐ No

Has your child ever been arrested or taken to Juvenile Court? ☐ Yes ☐ No

Has your child ever used alcohol or drugs? ☐ Yes ☐ No

Has your child ever set a fire or shown any fascination with fire? ☐ Yes ☐ No

Has your child been suspended/detention at school for negative behaviors? ☐ Yes ☐ No

SCHOOL ABSENCE HISTORY

In the current or most recent semester, has your child's emotional or behavioral health caused them to miss school? ☐ Yes ☐ No

Days Absent ___ Days Late to School ___ Called to Come Home ___

FIREARMS

Are there firearms in **your** home? ☐ Yes ☐ No

If yes, are they secured? ☐ Yes ☐ No

How are they secured: ☐ trigger locks ☐ gun safe ☐ hidden ☐ locked in closet ☐separate from ammunition

Are firearms in any other home your child might visit? ☐ Yes ☐ No

If yes, whose home? _____

If yes, are they secured? ☐ Yes ☐ No

How are they secured: ☐ trigger locks ☐ gun safe ☐ hidden ☐ locked in closet ☐separate from ammunition

Are firearms in any other home your child might visit? ☐ Yes ☐ No

If yes, whose home? _____

If yes, are they secured? ☐ Yes ☐ No

How are they secured: ☐ trigger locks ☐ gun safe ☐ hidden ☐ locked in closet ☐separate from ammunition

TREATMENT HISTORY

Has your child ever been evaluated for higher level of care treatment? This includes inpatient admissions, day treatment services, residential treatment programs and hospital emergency room visits, even if they did not result in an admission. __ Yes __ No

Name of Provider/Facility	Dates of Treatment	Reason

Has your child ever received **OUTPATIENT** psychological or psychiatric services? __ Yes __ No

Name of Provider	Dates	Reason	Did this help?

CURRENT HEALTH AND NUTRITION STATUS

Does your child have any medical concerns, chronic or current? ☐Yes☐ No

_____

_____

Is your child receiving any ongoing medical treatment at this time? ☐ Yes ☐ No

_____

Does your child need to see a doctor currently for any medical concern? ☐Yes ☐ No

_____

When did your child last see a healthcare provider for any reason?
Date: _____ Reason: _____

Does your child have any current problems or complaints of **physical** pain? ☐ Yes ☐ No
If ***yes***, please rate intensity by circling one number below:

0 1 2 3 4 5 6 7 8 9 10
None Unbearable

Are your child's current immunizations current and complete? ☐Yes ☐ No

Does your child have any hearing problems? ☐ Yes ☐ No

_____

Does your child have vision problems? ☐Glasses ☐Contacts

_____

Does your child have problems with gross motor coordination: ☐Yes ☐No

_____

_____

Does your child have any problems with fine motor coordination: ☐ Yes ☐ No

_____

_____

Describe any problems with speech articulation. ☐ Yes ☐ No

_____

_____

Has your child received speech therapy? ☐ Yes ☐ No

_____

_____

Has your child had any of the following?

Encephalitis ☐	Mumps ☐
Otitis Media ☐	Chicken Pox ☐
Lead Poisoning ☐	Measles ☐
Seizures ☐	Whooping Cough ☐
Scarlet Fever ☐	Pneumonia ☐

Any other diseases (please specify): _____

Has your child had any accidents resulting in any of the following?

Broken Bones ☐	Stomach Pumped ☐
Severe Lacerations ☐	Chicken Pox ☐
Head Injury ☐	Lost Teeth ☐
Severe Bruises ☐	

Any other accident related injuries: _____

Does your child currently have bladder control concerns? ☐ Yes ☐ No

Does your child currently have bowel control concerns? ☐ Yes ☐ No

Does your child have any appetite/eating concerns? ☐ Yes ☐ No

☐ Overeats ☐Undereats ☐ Binge/Purge ☐Hoards Food

Has your child gained/lost **10 pounds/10%** of their body weight in the past 6 months? ☐ Yes ☐ No

_____

_____

Does your child have any sleep concerns? ☐ Yes ☐No

☐ Falling Asleep ☐ Staying Asleep ☐ Wakes Up Early ☐ Sleeps too Much

Does your child have any known allergies to medications, foods etc.? ☐ Yes ☐No

_____

_____

List **ALL** medications, supplements, vitamins, etc. that your child is currently taking.
(Include both prescribed and over the counter medications and any other items.)

Medication/ Supplement	Dosage/ Frequency	Date Begun	Reason	Doctor

Is your child taking these medications as prescribed? ☐ Yes ☐ No

_____

_____

Has your child **EVER** been prescribed medications for mental health? ☐ Yes ☐ No

Medication	Dates Taken	Why was it stopped?	Did it help?	Doctor

Has your child ever had an adverse reaction to medication? ☐ Yes ☐ No

_____

_____

_____

Will any medication listed need to be ***SELF-ADMINISTERED*** by your child during the program day: ☐ Yes ☐ No

If ***yes***, please list the medications below:

Medication	Dosage	Time to be Taken

Please provide your signature for authorization:

_____

Parent/Guardian Signature Date

Do you give authorization for our staff to supervise self-administration by your child of ☐Tylenol (Acetaminophen) or ☐Advil (Ibuprofen) ***during the program day*** for symptoms of pain or headache?

If yes, please provide your signature for authorization:

_____

Parent/Guardian Signature Date

DO NOT WRITE IN THIS BOX. GO TO THE NEXT PAGE.

DOB_____ Weight_____ Height_____ BMI_____

I have reviewed this Current Health and Nutrition Status and have determined that in accordance with established criteria, further evaluation/referral IS/IS NOT necessary at this time.

_____

Signature/Date

When Indicated document referrals:

_____

_____

PARENT REPORT-PART TWO
(Revised 6/2019)

Please list all family members in home:

Name:	Relationship:	Age:
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____
_____	_____	____

FAMILY RELATIONSHIPS:

How do child and mother get along?

_____

_____

_____

How do child and father get along?

_____

_____

_____

How do child and siblings get along?

_____

_____

_____

Are biological parents married? ☐ Yes ☐ No Year married _____

Are parents separated? ☐ Yes ☐No Date Separated: _____

Are parents divorced: ☐Yes ☐No Date Divorced: _____

Briefly state reasons for separation/divorce:

_____

_____

Are there current custody issues? ☐Yes ☐No *If yes, please explain*

_____

_____

What are the custody/visitation arrangements?

_____

_____

Has either parent remarried? *If yes, please elaborate*

_____

_____

Please provide a written copy of the current/most recent parenting plan and/or relevant court orders.

PEER RELATIONSHIPS

How many friends does your child have? _____

Are they close in age? ☐ Yes ☐No

Is it hard for your child to make friends? ☐Yes ☐No

In general, does your child get along with other children? ☐ Yes ☐ No

Do you have concerns about your child's peer relationships? ☐Yes ☐ No If *yes*, please explain

_____

_____

Has your child ever been the victim of bullying or bullied another child? ☐Yes ☐ No

_____

_____

If your child struggles to make friends/get along with other children, please describe their struggles:

_____

_____

_____

FAMILY HISTORY FOR EMOTIONAL AND BEHAVIORAL PROBLEMS

BIOLOGICAL MOTHER'S FAMILY OF ORIGIN

	Mother	GM	GF	Uncle	Uncle	Aunt	Aunt	NA
Aggression, Defiant/ Oppositional Behavior	☐	☐	☐	☐	☐	☐	☐	☐
ADHD, Impulse Control	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐	☐	☐	☐
Autism Spectrum Dis.	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐
Did not complete High School	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis/Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐
Depression for more than one week	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Tics, Tourette's, Trichotillomania	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Self-Harming Behavior	☐	☐	☐	☐	☐	☐	☐	☐
Suicidal Behaviors	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Drug Use/Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Antisocial Behavior/ Arrests	☐	☐	☐	☐	☐	☐	☐	☐
Physical Abuse Perpetrator	☐	☐	☐	☐	☐	☐	☐	☐
Physical Abuse Victim	☐	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse Perpetrator	☐	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse Victim	☐	☐	☐	☐	☐	☐	☐	☐

Comments/Explanations:

BIOLOGICAL FATHER'S FAMILY OF ORIGIN

	Father	GM	GF	Uncle	Uncle	Aunt	Aunt	NA
Aggression, Defiant/ Oppositional Behavior	☐	☐	☐	☐	☐	☐	☐	☐
ADHD, Impulse Control	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐	☐	☐	☐
Autism Spectrum Dis.	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐
Did not complete High School	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis/Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐
Depression for more than one week	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Tics, Tourette's, Trichotillomania	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Self-Harming Behavior	☐	☐	☐	☐	☐	☐	☐	☐
Suicidal Behaviors	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Drug Use/Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Antisocial Behavior/ Arrests	☐	☐	☐	☐	☐	☐	☐	☐
Physical Abuse Perpetrator	☐	☐	☐	☐	☐	☐	☐	☐
Physical Abuse Victim	☐	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse Perpetrator	☐	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse Victim	☐	☐	☐	☐	☐	☐	☐	☐

Comments/Explanations:

_____

_____

BIOLOGICAL SIBLINGS OF CHILD

	Brother	Brother	Brother	Sister	Sister	Sister	NA
Aggression, Defiant/ Oppositional Behavior	☐	☐	☐	☐	☐	☐	☐
ADHD, Impulse Control	☐	☐	☐	☐	☐	☐	☐
Learning Disabilities	☐	☐	☐	☐	☐	☐	☐
Autism Spectrum Dis	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐
Did not complete High School	☐	☐	☐	☐	☐	☐	☐
Psychosis/Schizophrenia	☐	☐	☐	☐	☐	☐	☐
Depression for more than one week	☐	☐	☐	☐	☐	☐	☐
Anxiety Disorder	☐	☐	☐	☐	☐	☐	☐
Tics, Tourette's, Trichotillomania	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐
Self-Harming Behavior	☐	☐	☐	☐	☐	☐	☐
Suicidal Behaviors	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐
Drug Use/Abuse	☐	☐	☐	☐	☐	☐	☐
Antisocial Behavior/ Arrests	☐	☐	☐	☐	☐	☐	☐
Physical Abuse Perpetrator	☐	☐	☐	☐	☐	☐	☐
Physical Abuse Victim	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse Perpetrator	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse Victim	☐	☐	☐	☐	☐	☐	☐

Comments/Explanations:

_____

_____

DEVELOPMENTAL HISTORY:

1. How was the mother's health during the pregnancy?
☐ Good ☐ Fair ☐ Poor ☐ Unknown
2. Were any substances or medications used during pregnancy? ☐ Yes ☐No

_____

_____

3. Was there toxemia or eclampsia? ☐ Yes ☐ No ☐I don't know

4. Was there Rh factor incompatibility? ☐Yes ☐ No ☐ I don't know

5. Was your child born on schedule? ☐ Yes ☐ No ☐ I don't know

_____

_____

6. Were they any complications during labor or delivery? ☐ Yes☐No

_____

_____

7. Was the delivery: ☐Vaginal ☐Breech ☐Caesarian ☐ Forceps/Vacuum

8. What was your child's birth weight? _____

9. Did your child experience any health complications during or after birth? ☐ Yes ☐ No

_____

_____

10. Was your child oxygen deprived during the pre or post-natal period? ☐ Yes ☐ No

_____

_____

11. Did mother experience complications/problems during or following delivery? ☐ Yes ☐No

_____

_____

INFANCY: (0-36 months)

1. Were there any early infancy feeding problems? ☐ Yes ☐ No ☐ I don't know
2. Was your child colicky? ☐ Yes ☐ No ☐ I don't know
3. Were there early infancy sleep pattern disturbances? ☐ Yes ☐ No ☐ I don't know
4. Did your baby suffer from apnea? ☐ Yes ☐ No ☐ I don't know
5. Were there problems with the infant's responsiveness? ☐ Yes ☐ No ☐ I don't know
6. Did your child experience health problems during infancy? ☐ Yes ☐ No ☐ I don't know

_____

_____

7. Was your child a difficult baby? ☐ Yes ☐ No ☐ I don't know

_____

_____

8. How did your baby (up to age 3) behave with other people?

   ☐ More sociable than average ☐ Average sociability

   ☐ More avoidant of others/more unsocial than average

9. When he or she wanted something, how insistent was her or she?

   ☐ Very insistent ☐ Pretty insistent ☐ Average

   ☐ Not very insistent ☐ Not at all insistent

10. How would you rate the activity level of your child as an infant and toddler?

    ☐ Very active ☐ Active ☐ Average

    ☐ Less Active ☐ Not Active

DEVELOPMENTAL MILESTONES:

1. At what age did your child sit up?
   ☐3-6 mos. ☐7-12 mos. ☐ Over 12 mos. ☐Don't know

2. At what age did your child crawl?
   ☐ 6-12 mos. ☐13-18 mos. ☐Over 18 mos. ☐Don't know

3. At what age did your child walk?
   ☐Under 1 yr. ☐1-2 yrs. ☐2-3 yrs. ☐Don't know

4. At what age did your child speak single words (other than "mama" or dada")?
   ☐9-13 mos. ☐14-18 mos. ☐19-24 mos. ☐25-36 mos.
   ☐37-48 mos. ☐Don't know

5. At what age did your child string two words together?
   ☐9-13 mos. ☐14-18 mos. ☐19-24 mos. ☐25-36 mos.
   ☐37-48 mos. ☐Don't know

6. At what age did your child begin to sleep through the night?
   ☐ Under 1 yr. ☐1-2 yrs. ☐2-3 yrs. ☐3-4 yrs. ☐Over 6
   ☐Not yet ☐ Don't know

7. At what age was your child able to comfortably separate from you and stay with non-family members (e.g. daycare, babysitters, pre-school, etc):
   ☐Under 1 yr. ☐1-2 yrs. ☐2-3 yrs. ☐4-5 yrs ☐ 6-7 yrs. ☐ Over 7
   ☐Not yet ☐ Don't know

8. By what age was your child toilet trained?
   ☐Under 1 yr. ☐1-2 yrs. ☐2-3 yrs. ☐4-5 yrs ☐Over 6
   ☐Not yet ☐ Don't know

9. Approximately how much time did toilet training take from onset to completion?
   ☐Less than one mo. ☐1-2 mos. ☐2-3 mos. ☐More than 3 mos. ☐Don't know

ACTIVITY AND DAILY LIVING ASSSSMENT

1. Please list the sports your child most likes to partake in. For example: swimming, baseball, skating, skate boarding, bicycling, fishing, etc. ☐NONE

   _____

   _____

   _____

2. Please list your child's favorite hobbies/activities other than sports. For example: cards, books, piano, autos, crafts, etc. Do not include listening to music or TV. ☐NONE

   _____

   _____

   _____

3. Please list any organizations, clubs, teams or groups your child belongs to. ☐NONE

   _____

   _____

   _____

4. Please list any jobs or regular chores your child has, both paid and unpaid.☐ NONE

   _____

   _____

5. What does do your child spent in most of their free time?

   _____

   _____

6. What activities does your child most enjoy doing with:

   Family: _____

   Friends: _____

   Alone: _____

7. Please describe your family's involvement with church, synagogue, or other places of worship.

   _____

8. Are there any special religious or cultural beliefs of practices that we should be aware of in providing care for your child? ☐ Yes ☐No *If yes, please elaborate*

   _____

   _____

   _____

EDUCATION HISTORY:

Please list the school(s) your child has attended:

1. Present School: _____
   Complete Address: _____
   What grade(s) has your child attended there? _____
   Academic Grades (A's, B's, C's, etc): _____
   Conduct: _____
   School Contact Person/Phone: _____

2. Prior School: _____
   City, State: _____
   What grade(s) did your child attend there? _____
   Academic Grades (A's, B's, C's, etc): _____
   Conduct: _____

3. Prior School: _____
   City, State: _____
   What grade(s) did your child attend there? _____
   Academic Grades (A's, B's, C's, etc): _____
   Conduct: _____

4. Prior School: _____
   City, State: _____
   What grade(s) did your child attend there? _____
   Academic Grades (A's, B's, C's, etc): _____
   Conduct: _____

5. Is your child <u>currently</u> receiving Special Education Services? ☐Yes ☐No
   If yes, please describe:
   _____

6. Has your child <u>ever received</u> Special Education Services? ☐ Yes ☐ No
   If yes, please describe:
   _____

7. Has your child repeated any grades? ☐ Yes ☐No *If yes, which grades and why?*
   _____

8. Has there been psychoeducation testing done? ☐ Yes ☐ No *If yes, what kind of testing and when was it done?*
   _____

If yes, please provide a copy of the most current testing for our records.

9. Do you plan for your child to return to their present school? ☐Yes ☐No ☐Uncertain
If no or uncertain, please explain:

_____

10. What would be your assigned public school? _____

11. Are there any <u>current</u> disciplinary actions pending at this time? ☐ Yes ☐ No

_____
_____
_____

12. Does your child have any <u>history</u> of disciplinary actions at school? ☐ Yes ☐ No

_____
_____
_____

13. What are your child's best/favorite subjects?

_____
_____

14. What are your child's worst/least favorite subjects?

_____
_____

15. Describe any problems with homework routine or completion?

_____
_____
_____