Demographic Form for YBH Treatment

1. **Please complete the form online in the patient portal BEFORE YOUR VISIT or**
2. **Please fill out below and RETURN BEFORE YOUR VISIT by mail or fax:**
   Fax: (507) 208-4016
   Youth Behavioral Health, 1027 7th Street NW, Suite 102, Rochester, MN 55901

Name of person completing questionnaire_____ Date_____

Child's Full Name: _____

Date of Birth: _____ Gender: ___ Male ___ Female ___Other

Home phone: _____ School: _____ Grade: _____

Address: _____
Street City State Zip

Parent #1 Name: _____ Cell or work phone: _____

Address: _____
Street City State Zip

Parent #2 Name: _____ Cell or work phone: _____

Address: _____
Street City State Zip

Parents are:

___ Married ___ Divorced ____ Separated ____Co-parenting, living together ____Co-parenting, living apart

If divorced, separated, or co-parenting, what is the custody arrangement? _____

Who referred your child to treatment at YBH?

Name: _____ Agency/Affiliation: _____

Address: _____

Phone:_____ Email:_____

Do we have your permission to be in contact with this person regarding your child's care? ___ Yes ___ No

---

Does your child carry any current diagnoses? ___ Yes ___ No

If yes, please list: _____

_____

What are your main concern/reasons for referring your child for treatment?

_____

_____

_____

_____

Is your child currently engaged in individual or group therapy? ___ Yes ___ No
If yes, please indicate:

Provider #1 name: _____ Phone number: _____

Approximate start date: _____ Reason:_____

Do we have permission to contact this provider regarding your child's care? ___ Yes ___ No

Provider #2 name: _____ Phone number: _____

Approximate start date: _____ Reason:_____

Do we have permission to contact this provider regarding your child's care? ___ Yes ___ No

Does your child see a psychiatrist and/or take psychopharmacological medication? ___ Yes ___ No
If yes, please indicate:

Provider name: _____ Phone number: _____

Approximate start date: _____ Reason:_____

Do we have permission to contact this provider regarding your child's care? ___ Yes ___ No

Has your child had any formal testing or evaluations? ___ Yes ___ No
If yes, please indicate type (e.g. neuropsychological, psychological, occupational therapy, etc.) and date:

_____

_____

_____

_____

Is your child on an IEP (Individual Education Plan)? ___ Yes ___ No
If yes, for what disability? _____

Please bring a copy of most recent evaluations and IEP to your intake appointment.