family & children's services

Client Information Form (Child)

Please complete the following questions as best as possible. Your therapist will review your responses with you during your session. If you need assistance, please see the front office staff.

Client Legal Name: _____ Name Child prefers to be called: _____

Date of Birth: _____ Age: _____ Gender: _____

Name of Person filling out this form: _____ ☐Client ☐Other Representative
Address: _____ May letters be mailed to you? ☐Yes☐No
City: _____ Zip: _____

Email: _____

Primary Phone Number: _____ ☐ Cell ☐ Landline
Relationship to Child: _____
May a detailed message be left? ☐ Yes ☐ No
Do you want phone appointment reminder? ☐ Yes ☐ No

Legal Mother's name: _____ Legal Mother's phone _____
May a detailed message be left? ☐ Yes ☐ No
Mother's address: _____

Legal Father's name: _____ Legal Father's phone: _____
May a detailed message be left? ☐ Yes ☐ No
Father's address: _____

Guardian: ☐ Yes ☐No Guardian Name: _____
Guardian address: _____
Guardian phone: _____May a detailed message be left? ☐Yes ☐No

Emergency Contact Person: _____ Relationship to client: _____
Phone Number: _____

If parents are divorced, what is the current court ordered custody arrangement:
☐ Joint Legal ☐ Joint Physical ☐ Full Physical ☐ Full Legal

Please List Other Individuals Living in Client's Home:

Name	Age	Birthday	Relationship

1. Briefly explain your reason for seeking services:

_____

_____

2. Please check any areas you would like assistance with:
☐ Legal ☐ Financial ☐ Food ☐ Housing
☐ Vocational ☐ Educational ☐ Transportation ☐ Child Care
☐ Health Care ☐ Public assistance ☐ Counseling ☐ Medication
☐ Unsure ☐ Other: _____ ☐ None

3. Does your child currently attend school/college/vocational training? ☐ Yes ☐ No
If Yes, Where: _____ Grade: _____

4. Do you have concerns about your child's behavior in school with the following:
☐ Attendance ☐ Defiance ☐ Suspensions/Expulsions
☐ Fighting with Peers ☐ Fighting with Staff ☐ Academic Performance/Grades
☐ Other: _____ ☐ No Concerns

5. Do you have an IEP? ☐ Yes ☐ No
Diagnosis: _____

6. Has your child been previously diagnosed with a mental health disorder? ☐ Yes ☐ No ☐ Unsure

7. Has your child ever had past treatment for:
☐ Substance Use ☐ Mental Health ☐ Both Substance Use and Mental Health
☐ No past treatment ☐ Unsure

8. Has your child ever stayed in the hospital for mental health reasons? ☐ Yes ☐ No ☐ Unsure
If yes, when? _____

9. Has your child ever experienced any of the following?
☐ Nightmares ☐ Bedwetting ☐ Sleepwalking ☐ Stuttering ☐ Thumb Sucking
☐ Nail Biting ☐ School Phobia ☐ Fire Setting ☐ Drugs/Alcohol
☐ Sexual Abuse ☐ Physical Abuse ☐ Witness to Abuse ☐ Verbal Abuse
☐ Self-harm Behavior ☐ Neglect ☐ Not Applicable ☐ Other: _____

10. Does your child have difficulty coping with any of the following?
☐ Change/new situation ☐ Making friends ☐ Keeping friends ☐ Losses
☐ Expressing emotions ☐ Anger ☐ Self-Esteem ☐ Other: _____

11. Have any of your **relatives** experienced any of the following mental health disorders?

	Yes, No, or Unsure	Relative (Ex: mother, father, grandparent, etc.)
Anxiety disorders		
Depressive disorder		
Bi-polar disorder		
Psychotic disorder		
Behavioral problems		
ADHD/ADD		
Substance use/abuse		
Eating disorders		
Other		

12. Please check any current or past health conditions your child has:

☐ Allergies	☐ Diabetes	☐ Heart Disease	☐ Asthma
☐ Seizures	☐ Head Injury	☐ Sleep Problems	☐ Chronic Pain
☐ Headaches	☐ Hearing Issues	☐ Vision Issues	☐ Cancer
☐ Kidney Disease	☐ Obesity	☐ Arthritis	☐ Stroke
☐ High Cholesterol	☐ Stomach Pains	☐ High Blood Pressure	☐ Other: _____
☐ None			

13. Does your child have a doctor? ☐ Yes ☐ No Doctor's name: _____

14. When was the last time your child saw a doctor? _____ ☐ Unsure

15. Please list your child's medications/dosage: _____
_____

16. Is your child allergic to any medications?: ☐ Yes ☐ No ☐ Unsure
If yes, please specify? _____

17. Has your child ever had surgery? ☐ Yes ☐ No ☐ Unsure
If yes, What for? When? _____

18. Does your child currently have any spiritual beliefs? ☐ Yes ☐ No ☐ Unsure
Has your child, in the past, had any spiritual beliefs? ☐ Yes ☐ No ☐ Unsure

19. Did the mother of the child experience any circumstances that would have interfered with normal bonding when the child was born? Please check all that apply:
☐ Premature Birth (how many weeks was the mother pregnant? _____)
☐ Child did not leave the hospital with mother
☐ Medical Problems at birth with mother or baby
☐ Unsure ☐ Other: _____

Please check any issues experienced while pregnant with child:
☐ Drug, Alcohol or Tobacco Use
☐ Bleeding, Infection or other Medical Issues
☐ Mother did not receive regular medical care while pregnant
☐ Unsure ☐ Other: _____

20. Was this a planned pregnancy? ☐ Yes ☐ No ☐ Unsure

21. Did mother receive regular medical care while pregnant? ☐ Yes ☐ No
If Yes, beginning in what month? _____

22. Did your child have any problems after birth? ☐ Yes ☐ No
If Yes, please explain: _____

23. How did your child behave as an infant?

☐ Happy	☐ Playful	☐ Irritable	☐ Hard to Care For	☐ Easy to Care For	
☐ Active	☐ Restless	☐ Liked to be Held	☐ Quiet	☐ Other: _____	

24. Please describe any concerns about the child's development in infancy and childhood (delays, trouble walking or crawling, social issues, etc.): _____

_____

_____

25. Is your child currently on probation? ☐Yes ☐No ☐Unsure
If Yes, Probation Officer's name: _____

26. Does your child currently participate in any extracurricular activities? ☐Yes ☐No ☐Unsure

27. Has your child's involvement in your hobbies/interests recently changed? ☐Yes ☐No ☐Unsure

28. Has your child participated in activities under the influence of drugs/alcohol? ☐Yes ☐No ☐Unsure

(Optional)

Substance Use History Questionnaire

DRUG CATEGORY (Includes nonmedical drug use)	Ever Used? Yes/ No	Age of first use	IV Use? Yes/ No	Date Last Used (e. g. 2015)	Frequency of Use Past 6 Months
ALCOHOL					
CANNABIS: Marijuana, hash oil, pot, weed					
STIMULANTS: Cocaine, crack, blow Methamphetamine — meth, ice, crank					
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine, speed, bennies, uppers					
BENZODIAZEPINES/ HYPNOTICS/ BARBITURATES: Valium, Librium, Xanax, Diazepam, roofies, downers, Quaalude					
HEROIN: smack, scat, brown sugar, dope					
STREET OR ILLICIT METHADONE					
OTHER OPIOIDS: Tylenol #2 & #3, Percodan, Percocet, Morphine, Dilaudid					
HALLUCINOGENS: LSD, PCP, mescaline, peyote, mushrooms, ketamine, ecstasy					
INHALANTS: glue, gasoline, aerosols, paint thinner, poppers, rush, whippets					
STEROIDS: Oxandrin, steroids, juice					
Non-Medical USE OF PRESCRIPTION DRUGS: _____					
Other: _____					

29. Does your child use social media? ☐ Yes ☐ No ☐ Unsure

What types of social media are used? _____

_____

30. Do you think your child's use of social media is inappropriate? ☐ Yes ☐ No ☐ Unsure

If so, in what way _____

_____

31. Everyone has strengths like patience, education, a good home or other things that they can use to help them reach their goals. **Some of my child's strengths are:**

☐ Active	☐ Family Support	☐ Independent	☐ Resilient
☐ Communication	☐ Happy	☐ Intelligent	☐ Resourceful
☐ Determined	☐ Hardworking	☐ Independent	☐ Self-sufficient
☐ Educated	☐ Humorous	☐ Musical	☐ Social

☐ _____

32. No one's life is perfect and we might have needs that brought us to FCS or that make our lives harder or keep us from reaching our goals. **My child needs are:** _____

_____

33. We all have abilities or special skills or talents like writing, arts, sports or hobbies that we are good at doing. These can make our lives better. **Some of my child's talents or abilities are**

☐ Sports	☐ TV	☐ Video Games	☐ Outdoor Activities
☐ Reading	☐ Walking	☐ Running	☐ Exercise
☐ Scrapbooking	☐ Dancing	☐ Volunteering	☐ Gardening
☐ Hiking	☐ Collecting	☐ Art	☐ Socializing
☐ Music	☐ None	☐ Other: _____	

34. Having choices or preferences makes changing or reaching goals a little easier. Choices could include things like when or where I have my appointments or whether I am part of a group or working with a counselor alone. **My choices or preferences for my child's treatment are**

_____

_____

35. What are your child's current sleep patterns like (how many hours of sleep per night, trouble falling to sleep, trouble staying asleep, etc.)?

_____

_____

35. How is your child's nutrition (number of meals per day, types of dfoods, unexpected weight loss.gain)?

_____

_____

36. Describe any other issues you would like to address:

_____

_____

_____

_____

_____