

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:
- | | | | |
|--------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Legal | <input type="checkbox"/> Financial | <input type="checkbox"/> Food | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Vocational | <input type="checkbox"/> Educational | <input type="checkbox"/> Transportation | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Health Care | <input type="checkbox"/> Public assistance | <input type="checkbox"/> Counseling | <input type="checkbox"/> Medication |
| <input type="checkbox"/> Unsure | <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> 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:
- | | | |
|--|--|--|
| <input type="checkbox"/> Attendance | <input type="checkbox"/> Defiance | <input type="checkbox"/> Suspensions/Expulsions |
| <input type="checkbox"/> Fighting with Peers | <input type="checkbox"/> Fighting with Staff | <input type="checkbox"/> Academic Performance/Grades |
| <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> 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:
- | | | |
|--|--|---|
| <input type="checkbox"/> Substance Use | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Both Substance Use and Mental Health |
| <input type="checkbox"/> No past treatment | <input type="checkbox"/> 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?
- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Stuttering | <input type="checkbox"/> Thumb Sucking |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> School Phobia | <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Drugs/Alcohol | |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Witness to Abuse | <input type="checkbox"/> Verbal Abuse | |
| <input type="checkbox"/> Self-harm Behavior | <input type="checkbox"/> Neglect | <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Other: _____ | |
10. Does your child have difficulty coping with any of the following?
- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Change/new situation | <input type="checkbox"/> Making friends | <input type="checkbox"/> Keeping friends | <input type="checkbox"/> Losses |
| <input type="checkbox"/> Expressing emotions | <input type="checkbox"/> Anger | <input type="checkbox"/> Self-Esteem | <input type="checkbox"/> 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:
- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing Issues | <input type="checkbox"/> Vision Issues | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Obesity | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Pains | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> None | | | |
13. Does your child have a doctor? Yes Doctor's name: _____
 No
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?
- | | | | | |
|---------------------------------|-----------------------------------|---|---|---|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Playful | <input type="checkbox"/> Irritable | <input type="checkbox"/> Hard to Care For | <input type="checkbox"/> Easy to Care For |
| <input type="checkbox"/> Active | <input type="checkbox"/> Restless | <input type="checkbox"/> Liked to be Held | <input type="checkbox"/> Quiet | <input type="checkbox"/> 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:**
- | | | | |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> Active | <input type="checkbox"/> Family Support | <input type="checkbox"/> Independent | <input type="checkbox"/> Resilient |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Happy | <input type="checkbox"/> Intelligent | <input type="checkbox"/> Resourceful |
| <input type="checkbox"/> Determined | <input type="checkbox"/> Hardworking | <input type="checkbox"/> Independent | <input type="checkbox"/> Self-sufficient |
| <input type="checkbox"/> Educated | <input type="checkbox"/> Humorous | <input type="checkbox"/> Musical | <input type="checkbox"/> Social |
| <input type="checkbox"/> _____ | | | |
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**
- | | | | |
|---------------------------------------|-------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Sports | <input type="checkbox"/> TV | <input type="checkbox"/> Video Games | <input type="checkbox"/> Outdoor Activities |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Walking | <input type="checkbox"/> Running | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Scrapbooking | <input type="checkbox"/> Dancing | <input type="checkbox"/> Volunteering | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Hiking | <input type="checkbox"/> Collecting | <input type="checkbox"/> Art | <input type="checkbox"/> Socializing |
| <input type="checkbox"/> Music | <input type="checkbox"/> None | <input type="checkbox"/> 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 foods, unexpected weight loss/gain)?
- _____
36. Describe any other issues you would like to address:
- _____
- _____
- _____
- _____

Note: The completed form can either be brought to the first session or emailed to info@fcs-midland.org prior to the session.