



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.

Notes:

- 1. The completed form can either be brought to first session or emailed prior to info@fcs-midland.org
- 2. Please bring your insurance card to your first session
- 3. If you would like to apply for our sliding fee scale, you must also bring proof of household income (most recent pay stub or W-2) to the session.

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: _____

List person(s) authorized to make, change, or cancel appointment's on client's behalf:

Name: _____ Name: _____

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

Name: _____

Date of Birth: _____

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? _____

Name: _____

Date of Birth: _____

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 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

Name: _____

Date of Birth: _____

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

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 _____

Name: _____

Date of Birth: _____

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.)?

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

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

Name: _____

Date of Birth: _____

(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: _____					