



CHILD'S INFORMATION:

NAME: _____ FCS ID#: _____ KAECSES #: _____
First name Middle Initial Last Name

DOB: _____ AGE: _____ SS NUMBER: _____ GENDER: MALE FEMALE

ADDRESS: _____ APT.#: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

PHONE NUMBER: _____
Home Cell

RACE/ETHNICITY OF CHILD
 African American/Black Asian Caucasian/White Chinese Hawaiian Japanese Native American Vietnamese Hispanic Biracial Other

Are there any communication barriers for the child or parent/guardian? _____ If so, please explain: _____

CAREGIVER INFORMATION: PARENT RELATIVE GUARDIAN RESOURCE PARENT

NAME: _____
Last name First Name Middle Initial

ADDRESS: (if different) _____ APT.#: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

PHONE NUMBER: _____
Home Cell Work

Number of household members: _____

Are there any immediate family members in the military? _____ If so, have they served in combat? _____

Who is legally authorized to receive information about and make decisions regarding this child's care?

Name and Relationship

CASE MANAGER/PO: _____ AGENCY: _____ PHONE: _____ N/A

WHO REFERRED YOU TO OUR AGENCY: _____

WHAT PROBLEMS BRING YOU TO SEEK TREATMENT FOR THIS CHILD: _____

IS TREATMENT COURT ORDERED? YES NO

EMPLOYMENT INFORMATION: Full-time Student Part-time Student Employed N/A

Name of Employer: _____ Job Title: _____

LEGAL HISTORY:
Has the child been charged with a crime Yes No Is the child on probation? Yes No

If yes, please explain: _____

Child's Name: _____

SUBSTANCE USE HISTORY:

NONE

Alcohol Other substance use _____

Attended alcohol/drug abuse treatment: Yes No Has the child been told that they have an alcohol/drug problem: Yes No

GAMBLING HISTORY (PLEASE COMPLETE IF YOUR CHILD IS 12 YEARS OF AGE OR OLDER):

Are you seeking services for a gambling addiction: Yes No

If so, has the youth ever lied about their gambling: Yes No

If so, has the youth ever increased bets to get the same sense of action: Yes No

SCHOOL FUNCTIONING:

Current School: _____ Elementary Middle School High School

Grade: _____ Teacher's Name: _____ School Phone Number: _____

Past / Present truancy Yes No

Expulsions Yes No Number _____ Dates _____

Suspensions Yes No In school Out of school Number _____ Dates _____

Asked to leave a daycare/preschool Yes No Number _____ Dates _____

504 Plan Special Education / IEP _____

SOCIAL, PLAY AND RECREATION: Describe the child's social, play and recreational interests:

PLACEMENT HISTORY: N/A

Type: Resource home, shelter, residential facility _____ Kinship home

Dates/length of stay: _____

Reason for moving: _____

Type: Resource home, shelter, residential facility _____ Kinship home

Dates/length of stay: _____

Reason for moving: _____

Please document additional placements on a separate page

CASE PLAN GOAL Reintegration Adoption Guardianship Maintenance at Home OPPLA NA

CONCURRENT CASE PLAN GOAL Adoption Guardianship OPPLA NA

MENTAL HEALTH HISTORY:

No previous therapy

Outpatient Treatment

Type of treatment: (Circle all that apply) Individual therapy family therapy group therapy

Provider: _____

Dates of treatment: _____

Reason for treatment: _____

Type of treatment: (Circle all that apply) Individual therapy family therapy group therapy

Provider: _____

Dates of treatment: _____

Reason for treatment: _____

Child's Name: _____

INPATIENT PSYCHIATRIC HOSPITALIZATION:

Previously hospitalized: Yes No N/A Multiple Hospitalizations: Yes _____

Last psychiatric facility _____ Date Admitted _____ Date Dismissed _____
Please document additional hospitalizations on a separate sheet

PRIMARY CARE PHYSICIAN (PCP):

NAME: _____ PHONE: _____

ADDRESS: _____

Visit/Checkup with PCP within the past 12 months: YES NO Regular preventative health screens: YES NO

CURRENTLY PRESCRIBED MEDICATIONS (Medication, dosage and prescribing physician):

Has the child been consistently taking these medications as prescribed Yes No

PATIENT MEDICAL/HEALTH: (Please check all that apply – past or current)

<u>N/A</u>	<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>	<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>	<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT EAR INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DENTAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SIGNIFICANT WT. GAIN/LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTRO INTESTINAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEAD INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Are you currently being seen for any of the above? YES NO IF YES, PLEASE DESCRIBE _____

History of hospitalization due to a medical condition: YES NO IF YES, PLEASE DESCRIBE _____

Medication Allergies _____

NUTRITION: (Please check all that apply – past or current)

	<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>		<u>PAST</u>	<u>CURRENT</u>	<u>N/A</u>
INCREASED APPETITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BINGE EATING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DECREASED APPETITE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HOARDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Are you currently being seen for any of the above? YES NO IF YES, PLEASE DESCRIBE _____

Food Allergies _____

I have made myself throw-up after eating YES NO I do not eat a wide variety of healthy foods YES NO

PAIN:

PAST CURRENT N/A
CHRONIC PAIN IF YES, PLEASE DESCRIBE: _____

Are you currently being seen for any of the above? YES NO IF YES, PLEASE DESCRIBE _____

I experience a decrease in my ability to function in life due to this pain YES NO

PSYCHIATRIC HISTORY:

	<u>PAST</u>	<u>OR</u>	<u>CURRENT</u>		<u>PAST</u>	<u>OR</u>	<u>CURRENT</u>		<u>PAST</u>	<u>OR</u>	<u>CURRENT</u>
ADHD	<input type="checkbox"/>		<input type="checkbox"/>	ABUSE: SEXUAL	<input type="checkbox"/>		<input type="checkbox"/>	OTHER _____	<input type="checkbox"/>		<input type="checkbox"/>
ANXIETY	<input type="checkbox"/>		<input type="checkbox"/>	ABUSE: PHYSICAL	<input type="checkbox"/>		<input type="checkbox"/>				
DEPRESSION	<input type="checkbox"/>		<input type="checkbox"/>	EATING DISORDER	<input type="checkbox"/>		<input type="checkbox"/>				

Child's Name: _____

DEVELOPMENTAL HISTORY:

PREGNANCY: FULL TERM PREMATURE LATE DELIVERY: NORMAL DELIVERY C-SECTION

Problems during pregnancy _____

MILESTONES:

WALKING _____ MONTHS TALKING _____ MONTHS TOILET TRAINED _____ MONTHS

FAMILY MEDICAL HISTORY: (Please mark each that apply with "1" for immediate family "2" for extended family)

- | | | | |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Psychiatric hospitalizations |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Alcohol/drugs |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Antisocial behavior (difficulties – police/violence) | |

VISITATION ARRANGEMENTS:

Are there any custody/visitation arrangements? Please describe, noting any court orders:

FAMILY, CULTURE AND RELIGION: Describe the child's family, cultural and religious connections.

BEREAVEMENT AND GRIEF: Has the child experienced grief and or loss? If so, describe how your family is supported socially, spiritually and culturally.

GENERAL FUNCTIONING: (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cheerful/happy mood most of the time | <input type="checkbox"/> Extreme ups and downs in mood | <input type="checkbox"/> Conflict with authority figures |
| <input type="checkbox"/> Sad or tearful most of the time | <input type="checkbox"/> Irritability/anger | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Distinct periods of nonstop activity | <input type="checkbox"/> Physical cruelty to animals |
| <input type="checkbox"/> Withdrawn behaviors | <input type="checkbox"/> Exaggerated view of abilities | <input type="checkbox"/> Physical aggression |
| <input type="checkbox"/> Difficulty thinking | <input type="checkbox"/> Fast/rapid speech | <input type="checkbox"/> Verbal threats to harm others |
| <input type="checkbox"/> Under active/sluggish behavior | <input type="checkbox"/> Feels rested after 3-4 hours sleep/ night | <input type="checkbox"/> Threat to kill with intent /plan |
| <input type="checkbox"/> Intentional self harm | <input type="checkbox"/> Fearless/engaging in reckless activities | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Fearful of places, situations or people | <input type="checkbox"/> Extreme conflict with siblings |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Worries about _____ | <input type="checkbox"/> Running away |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Wetting accidents | <input type="checkbox"/> Poor social skills |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Soiling Accidents | <input type="checkbox"/> Inability to complete tasks |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Sexual inappropriate touching of others | <input type="checkbox"/> Inability to sustain attention |
| <input type="checkbox"/> Takes more than an hour to fall asleep | <input type="checkbox"/> Sexual play with toys or objects | <input type="checkbox"/> Inability to remain seated |
| <input type="checkbox"/> Night waking for longer than 30 minutes | <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Overactive/hyperactive behavior |
| <input type="checkbox"/> Hard to wake up in the morning | <input type="checkbox"/> Intentional vomiting/purging | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Unable to sleep in own bed through the night | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Poor self-care/poor hygiene |
| <input type="checkbox"/> Sleepwalking | | |

WHEN DID THESE CONCERNS BEGIN?

Child's Name: _____

HOW OFTEN DO THESE OCCUR?

IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR CHILD?

CONSENT AND AUTHORIZATION

By signing below you are:

- Authorizing Youthville to provide the client with mental health services.
- Acknowledging that Youthville will provide these services in a confidential and professional manner that complies with State and Federal laws and professional standards.
- Acknowledging that you have been informed that services not covered by the insurance company will be the responsibility of the client (or parent or guardian if the client is under 18 years of age).
- Acknowledging that you have received a copy of the Client Rights and Responsibilities.

CONSENT AND AUTHORIZATION: (MUST BE SIGNED BEFORE WE CAN PROVIDE SERVICES)

Signature X _____ Date _____

Must Be Signed by Client or by Parent or Guardian if Client is Under 18 Years of Age.

Youthville is an equal opportunity employer. Services are provided to people without regard to race, religion, color, sex, ancestry, national origin, handicap, age or political affiliation.