SANFORD HEALTH

Client #______________

Child Service Application

Name of Child: ______________________________________ Date:______________________
Child's former name if applicable:____________________ Sex: ☐ Male ☐ Female
SSN:______________________ Date of Birth:_______________ Age:______________________

Name of person completing form:____________________ Relationship to Child:_______________
Who has current legal guardianship of child? (if different than parent):______________________
Present address:____________________________ City:_____________ State:_______ Zip:________
County of residence:_____________Home Phone:_______Work Phone:_______Cell Phone:________

(Completion of this section is optional) Child's Race: ☐ White ☐ Black ☐ Hispanic
☐ Asian/Pacific ☐ Multi-racial ☐ Other_____________
☐ Native American (Enrolled Tribal Member ☐ Yes ☐ No, where________________________

Who referred this child to Sanford Health Behavioral Health Center?______________________

PRESENT PLACEMENT INFORMATION

Child Currently Lives:

- ☐ At home with family
- ☐ At a relative's home (name and relationship of custodial adults in this home):
  ____
- ☐ In a foster home (name of foster parents)______________________________________
- ☐ At a group home or residential facility (name of facility)_________________________
- ☐ Other (please explain)____

  Length of time child has been at current placement?:______________________

FAMILY HISTORY

Biological Mother's name:____________________Age:_____Lives with child?☐ Yes ☐ No
Has the mother or any of the mother's relatives experienced problems similar to those currently experienced by the child? ☐ Yes ☐ No. If yes, please Explain:__________________________
____

Biological Father's Name:____________________Age:_____Lives with child? ☐ Yes ☐ No
Has the father or any of the father's relatives experienced problems similar to those currently experienced by the child? ☐ Yes ☐ No. If yes, please Explain:__________________________
____

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MARITAL

Are the biological parents of the child ☐ Married ☐ Separated ☐ Divorced
☐ Living together ☐ Never were together ☐ Widowed ☐ Other________________________

Are the biological parents now remarried or living with a significant other? ☐ Yes ☐ No

Please describe any abuse, chemical dependency or legal difficulties in the child's immediate relatives:____

____

Other people residing in the same household with child:

Name	Age	Occupation	Relationship to Child

EARLY CHILDHOOD DEVELOPMENTAL HISTORY

Was the pregnancy: a) planned? ☐ Yes ☐ No
b) welcomed? ☐ Yes ☐ No
c) stressful? ☐ Yes ☐ No

At any time during the pregnancy did the mother use:
a) Prescribed medications ☐ Yes ☐ No If yes, how much? ____________________
b) Recreational drugs ☐ Yes ☐ No If yes, how much?____________________
c) alcohol ☐ Yes ☐ No If yes, how much?____________________
d) Tobacco ☐ Yes ☐ No If yes, how much? ____________________

Were there any medical concerns or other issues during this pregnancy regarding mother and/or baby? ____

____

At the time of birth did the baby have?
☐ trouble breathing ☐ Yellow jaundice ☐ blood transfusion
☐ resuscitation ☐ jitteriness ☐ physical injuries
☐ twin ☐ seizures/fits ☐ trouble sucking
☐ birth defects ☐ cord around neck ☐ intensive care
☐ fevers or low temperature

Is your child adopted? ______ Does child know?___If not, do you intend to tell the child?______
At what age was the child placed in your home?_________At what age when adopted? ________

Do you have any concerns about your child's motor or muscle development: ☐ Yes ☐ No
If so, please describe… ____

____
Do you have any concerns regarding your child's language development: ☐ Yes ☐ No
If so, please describe…____

____

SCHOOL/WORK
Level of Education:_________ Grade: ______ Current School: ______________________________
Class Placement: ☐ Mainstream ☐ Special Class (where)___________________________________
Teacher or Advisor's name:_____________________________ IEP in place? ☐ Yes ☐ No

Does the child have any learning disabilities? ☐ Yes ☐ No
If yes, please describe:____

Please list all the schools the child has attended:

Name of School	Address of School	Grade(s) Attended

MEDICAL
Who is your child's medical doctor? ____
When was your child's last physical examination? _____________ Results: _________________________

Are there any medical problems we should be aware of and/or that may be impacting your child's mental health? ☐ Yes ☐ No If yes, please explain:_____________________________________

____

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Has your child been to the Emergency Room to visit in the last year? ☐ Yes ☐ No
If yes, what condition(s)? ______________________________

Has there been any history of head trauma, seizures, or loss of consciousness? ☐ Yes ☐ No
If yes, please explain: ______________________________

Has your child had past suicide attempts/thoughts? *(Please describe date and method.)*
How: ______________________________
When: ______________________________

Is your child allergic to or ever had an adverse reaction to any medications? ☐ Yes ☐ No
If yes, please explain: ______________________________

Does your child have any other allergies? ☐ Yes ☐ No
For example: foods, airborne ______________________________

Is your child pregnant? ☐ Yes ☐ No

Has there been mental health services involved with this child before? ☐ Yes ☐ No
If yes explain: ______________________________

Has your child ever been treated/experienced any of the following?

- ☐ Abnormal movements
- ☐ Birth or developmental problems
- ☐ Alcohol Abuse ☐ Drug Abuse
- ☐ ADHD/hyperactivity
- ☐ Anxiety ☐ Fears
- ☐ Failure to complete tasks
- ☐ Depression
- ☐ Eating problems ☐ too much ☐ too little
- ☐ Head injury/concussion
- ☐ Other serious injury or accident
- ☐ Seizure
- ☐ Decreased interest in friends/activities
- ☐ Suspension/expulsion/truancy – school
- ☐ Yelling/swearing
- ☐ Hearing voices, seeing something others didn't
- ☐ Weight loss/gain
- ☐ Hospitalization
- ☐ Chronic pain
- ☐ Irritable
- ☐ Headaches, migraines
- ☐ Fights/stealing/lying
- ☐ Fear of germs
- ☐ Legal problems
- ☐ Destroying property
- ☐ Bedwetting/Incontinence
- ☐ Menses
- ☐ Sexually transmitted disease
- ☐ Setting fires
- ☐ Vision problems
- ☐ Hearing problems ☐ Speech
- ☐ Sleep disturbance or difficulty
- ☐ Other ______________

If illness is indicated, please comment on length and duration of problem: ______________________
____

CURRENT MEDICATION	DOSAGE	PRESCRIBED BY

PAST MEDICATIONS: ____
Do you take vitamins, herbal medications, diet supplements, or other over-the-counter medications? ☐ Yes ☐ No
If yes, what type, how much, how long? ____

Does your child use tobacco? ☐ Yes ☐ No How much:____________ How often? ____________
Does your child use caffeine? ☐ Yes ☐ No How much:____________ How often? ____________

LEGAL
Is your child currently on probation? ☐ Yes ☐ No Probation Officer:_______________________
Are there any current or pending legal actions against the child? ☐ Yes ☐ No
If yes explain:____

Is the County Social Services involved with this child or family? ☐ Yes ☐ No
If yes explain:____

Is your child/family currently involved in any custody disputes? ☐ Yes ☐ No
If yes explain:____

PROBLEM DESCRIPTION:
Please describe the problem(s) that brings the child to Sanford Health Behavioral Health Center at this time:____
____
____

What would you like to see change by coming here?_____________________________________
____
____

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Symptom	Frequently	Sometimes	Rarely	Never
Does your child				
Have trouble paying attention				
Make careless mistakes				
Not seem to listen when spoken directly to				
Have difficulty following through on instructions				
Struggle to be organized				
Fail to finish tasks or assignments				
Give up when he/she becomes frustrated				
Have trouble concentrating for long periods of time				
Tend to lose many of his/her belongings				
Becomes easily distracted by things going on around him/her				
Seem to be forgetful				
Fidget and squirm excessively				
Seem to have difficulty staying seated				
Seem to be driven by a motor				
Blurt out answers				
Run around excessively in inappropriate situations				
Have difficulty waiting his/her turn				
Have difficulty with peer relationships				
Interrupts others (e.g. butt into conversations or games)				

Would you consider your child to be depressed? ☐ Yes ☐ No
If yes, what are your concerns? ____

____

____

Would you consider your child to be anxious or worried? ☐ Yes ☐ No
If yes, what are your concerns? ____

____

Symptom	Frequently	Sometimes	Rarely	Never
Does your child				
Seem to have diminished interest in things they usually enjoy				
Have abnormal changes in his/her weight				
Demonstrate concerns regarding his/her eating habits				
Have low energy or seem fatigued				
Have feelings of worthlessness or hopelessness				
Have difficulty making decisions				
Have recurrent thoughts of death				
Think about suicide				
Ever hurt himself or herself on purpose				
Have difficulty falling or staying asleep				

Symptom	Frequently	Sometimes	Rarely	Never
Does your child:				
Have difficulty when they are separated from the family or home				
Have excessive fears about bad things happening				
Report physical symptoms when they are trying to avoid something				
Have *nightmares* regarding these events				
Experience reminders of the event that may trigger stress				
Try to avoid memories, conversations or activities associated with this event				
Complain of seeing or hearing things other people don't see or hear				
Find it difficult to control their worry				
Restless, feeling keyed up, or on edge				
Sleep disturbances				

Has your child ever experienced anything that has been difficult for him/her to cope with?
☐ Yes ☐ No If yes, please describe: ____

____

____

Symptom	Frequently	Sometimes	Rarely	Never
Does your child				
Lose his/her temper				
Argue with adults				
Refuse to follow the rules of adults				
Seem to deliberately annoy people				
Blame other people for his/her misbehavior or mistakes				
Seem touchy or easily annoyed by others				
Seem to be feeling resentful or angry				
Bully, threaten or intimidate other people				
Physically cruel to animals or people				
Seem to experience truancy from school				
Stay out at night despite your rules				
Run away from home				
Force people into sexual activity				
Engage in fire setting behavior				
Destroy other people's property				
Lie to get things from other people or avoid responsibility				
Has difficulty with eye contact, facial expression and/or body language				
Struggles to develop peer relations appropriate to developmental level				
Lacks shared enjoyment, interest or achievement with others (doesn't show, bring or point out objects of interest to others)				
Lacks social or emotional exchange with others				
Has abnormal level of focus or intensity regarding stereotyped or restricted patters of interest				
Has inflexible routines or rituals				
Repeats physical movements (hand flapping, finger twisting)				
Has persistent preoccupation with part of objects				

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Consent for Treatment and use of PHI: I acknowledge that I have consented to receive mental health and related services from staff of Sanford Health Behavioral Health which will be described in full in the treatment planning process. I understand that I must consent to receive services or I will not be served.

Client Signature: ____ Date ____________________________

Parent/Guardian
Signature ____ Date ____________________________