NORTHERN PINES MENTAL HEALTH CENTER

CLIENT INFORMATION—CHILD FORM
PRIVATE AND CONFIDENTIAL

TODAY'S DATE

CLIENT				
LAST NAME	FIRST NAME			MIDDLE INITIAL
DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY	
PARENTS				
	LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY
	LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY
HOME ADDRESS				
CITY	ZIP CODE		COUNTY	
HOME PHONE ☐Preferred	WORK PHONE ☐Preferred		CELL PHONE ☐Preferred	
Race/Ethnicity ☐ Black ☐White ☐Hispanic ☐Asian/Pacific Islander ☐American Indian/Alaskan Native ☐Other				
Primary Language				

EMERGENCY INFORMATION			
The name of the person to contact in the event of a medical emergency			
NAME	**RELATIONSHIP**	**PHONE**	**ADDRESS**
In the event of a medical emergency, I authorize Northern Pines Mental Health Center to contact the above person **Signature** **Date**			

CURRENT MENTAL HEALTH CONCERNS
The concern which led to child's appointment here is:
There are family circumstances that may be related to these concerns. ☐ Yes ☐ No (specify):
There are school circumstances that may be related to these concerns. ☐ Yes ☐ No (specify):
Child is currently receiving mental health services from another professional ☐ Yes ☐ No **Name** **Address** **Since (date)**

SELF-HARM CONCERNS	
☐ Yes ☐ No	Child has **recently experienced** a desire or urge to kill **her/himself.**
☐ Yes ☐ No	Child has **attempted** to kill **her/himself** in the past.
☐ Yes ☐ No	Child is **currently experiencing** thoughts or urges to injure or harm her/himself.
☐ Yes ☐ No	Child has **engaged** in self-injuries or harmful behaviors.
VIOLENCE CONCERNS	
☐ Yes ☐ No	Child has **recently experienced** a desire or urge to seriously harm or kill **someone else.**
☐ Yes ☐ No	Child has **attempted** to harm/hurt other people in the past (hitting, shoving, choking, punching, kicking, etc.)
☐ Yes ☐ No	Child has a history of violent or destructive behavior.

TREATMENT GOALS

What do you hope to change by having the child coming here?

CURRENT HOUSEHOLD INFORMATION (persons currently living in the child's household)

	Name	Relationship to child	Age	Gender	Place of Employment or School and grade
1					
2					
3					
4					
5					
6					

☐ Yes ☐ No Are there any other significant people who are not living in the child's household but are involved in the child's life (ex., step-parent, birth-parent, step or half-siblings, grandparents, foster family, family friends or others)?If Yes, list below

Name	Relationship to child	Age	Gender	Where they live

CHILD'S EDUCATION STATUS

School child attends: _____ Current grade: _____

Address of School: _____

_____

☐ Currently in Pre-school or Early Childhood Education
☐ Currently in Head-start

Special needs or concerns associated with the child's educational environment (check all that apply):

☐ Reading ☐ Getting along with school mates ☐ Attendance/skipping classes/refusal to go to school
☐ Writing ☐ Attention deficit/hyperactivity problems ☐ Other
☐ Math ☐ Hearing and understanding verbal information
☐ Speech ☐ Getting along with teachers

☐ Yes ☐ No Child is currently receiving special education services?
Type of Service: _____
Teacher: _____

LIFE EXPERIENCES

Child	Someone close to the child	The following experiences have happened to the child or someone close to the child:
☐ Yes ☐ No	☐ Yes ☐ No	Alcohol or drug use
☐ Yes ☐ No	☐ Yes ☐ No	Physical abuse or battering
☐ Yes ☐ No	☐ Yes ☐ No	Sexual abuse, molestation, or rape
☐ Yes ☐ No	☐ Yes ☐ No	Neglect
☐ Yes ☐ No	☐ Yes ☐ No	Physical disability
☐ Yes ☐ No	☐ Yes ☐ No	Chronic illness
☐ Yes ☐ No	☐ Yes ☐ No	Mental illness
☐ Yes ☐ No	☐ Yes ☐ No	Special Education services
☐ Yes ☐ No	☐ Yes ☐ No	Suicide or Suicide attempts
☐ Yes ☐ No	☐ Yes ☐ No	Loss of a loved one through death
☐ Yes ☐ No	☐ Yes ☐ No	Frequent moving or relocation
☐ Yes ☐ No	☐ Yes ☐ No	Natural disaster (flood, earthquake, tornado)

Child	Someone close to the child	The following experiences have happened to the child or someone close to the child:
☐ Yes ☐ No	☐ Yes ☐ No	Abduction or kidnapping
☐ Yes ☐ No	☐ Yes ☐ No	Removal from home/parents
☐ Yes ☐ No	☐ Yes ☐ No	Legal/court/incarceration/probation involvement

☐ Yes ☐ No Did the child have an significant developmental concerns: If Yes, please explain:

MEDICAL INFORMATION

Name of child's Physician/Medical Clinic: _____

Date of last physical exam: _____

Please sign the Consent for Release of Private Information form

Name of the Pharmacy used by the child: _____

CURRENT MEDICATIONS OF THE CHILD

	☐*Medication List Attached* Name of Medication	Reason	Amount /dose	Last dose taken was: (when)	Frequency	Date 1st started this medication	Take medication as prescribed?
1							☐ Yes ☐ No
2							☐ Yes ☐ No
3							☐ Yes ☐ No
4							☐ Yes ☐ No
5							☐ Yes ☐ No

☐ Yes ☐ No Any adverse reaction to the listed medications? _____

☐ Yes ☐ No Allergies: _____

Current medical issues of the child:

Specialist seen:

Previous surgeries:

Other previous hospitalization of child:

PAST MEDICAL HISTORY		**Please Explain**
☐ Yes ☐ No	Head Injuries	
☐ Yes ☐ No	Seizures	
☐ Yes ☐ No	Lead Poisoning	
☐ Yes ☐ No	Serious Illnesses	
☐ Yes ☐ No	Serious Injuries	
	Other Medical Issues	

MENTAL HEALTH HISTORY

	Name of Counselor/ Therapist/ Doctor	Name of the Clinic/ Hospital	Address/City/State	The Date(s) I went there were
1				
2				
3				
4				
5				

The following mental health problems were/are present in the child's family (parents, brothers, sisters, and other relatives):

☐ Depression
☐ Bipolar disorder (manic-depression)
☐ Schizophrenia
☐ Panic attacks
☐ Suicide
☐ Alcohol abuse/dependency
☐ ADHD/ADD (Hyperactivity)
☐ Other

ADDITIONAL SERVICES RECEIVED			
	Child has received help from <u>Social Services</u>	**Name of worker**	**Reason**
☐ Yes ☐ No	Financial Assistance		
☐ Yes ☐ No	Child Welfare Issues		
☐ Yes ☐ No	Case Management		
☐ Yes ☐ No	Other Social Services		
	I have received help from:	**Name of worker**	**Reason**
☐ Yes ☐ No	Child receives In-Home Family services		
☐ Yes ☐ No	Child receives Home Health/County Nursing Services		
☐ Yes ☐ No	Child receives Probation Services		
☐ Yes ☐ No	Child receives other Court/Legal Services		

CHEMICAL USE INFORMATION
ALCOHOL /DRUG USE

☐ Yes ☐ No Does the child use alcohol or drugs? Specify:

NICOTINE USE

The child uses the following tobacco products:		How often does the child use this product	Would you like this child to work on this nicotine issue?
☐ Yes ☐ No	Cigarettes		☐ Yes ☐ No
☐ Yes ☐ No	Chewing tobacco		☐ Yes ☐ No
☐ Yes ☐ No	Other (pipe, cigars, etc.)		☐ Yes ☐ No
☐ Yes ☐ No	Vapor		☐ Yes ☐ No

Signature of person completing the form:	Date completed:
Relationship to child:	

If your child is 12 years or older, please have your child complete page 5 by him/herself

CAGE-AID

1 ☐ Yes ☐ No Have you ever felt you ought to cut down on your drinking or drug use?
2 ☐ Yes ☐ No Have people annoyed you by criticizing your drinking or drug use?
3 ☐ Yes ☐ No Have you felt bad or guilty about your drinking or drug use?
4 ☐ Yes ☐ No Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

How many times have you participated in some type of gambling within the past month?
☐ Never ☐ Once ☐ 2-4 times ☐ 5-10 times ☐More than 10 times
Has your gambling created financial problems for your family?
☐ No ☐ Yes, in the past but not currently ☐ Yes, it is currently creating problems

Signature of Client	Date