Lighthouse Child & Family Services

Child Client Information Form

I. General Information

Child's Name _____Sex _____Age _____Date of Birth _____/_____/_____

___ Biological ___ Adopted - at age _____ Foster care since _____

Parents' Names and Phone Numbers (include stepparents, foster parents, etc.):

_____

_____

_____

Are parents: _____Married _____Separated _____Divorced _____Never Married

Referred by: _____

Primary reason you are concerned about your child:

_____

_____

_____

Race/Ethnic Background: ____White ___Black/African American ___Hispanic/Latino ____American Indian/Alaskan Native

____ Asian/Pacific Islander _____Other _____Prefer not to answer

II. Medical History

Name and address of child's physician/medical group _____

Last appointment with physician _____/_____/_____

Date of last physical (if differs from above) _____/_____/_____

Child's history of serious illness, injury, handicaps, or hospitalizations? ___Yes ___No - If yes, please describe and give dates:

_____

_____

List any major medical conditions in your immediate family (diabetes, cancer, etc.):

_____

_____

Please list all prescription medication your child is currently taking including vitamins, minerals, herbal remedies, and its purpose:

Name	Dosage	Prescribing Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any known allergies:

_____

_____

_____

Has your child ever had or been diagnosed with any of the following:

___ Arthritis
___ Attention Deficit Disorder
___ Brain Injury
___ Cancer
___ Chronic Pain
___ Eating Disorder
___ Asthma
___ Autism
___ Breathing Problems
___ Chronic Fatigue Syndrome
___ Diabetes
___ Fibromyalgia

___ Gastrointestinal Problems
___ Heart Problems
___ High Cholesterol
___ Menopause
___ Neurological Problems
___ Pain in Chest
___ Postpartum Depression
___ Stomach Aches
___ Ulcers
___ Other (please list) _____

___ Headaches
___ High Blood Pressure
___ Infectious Disease
___ Lyme Disease
___ Muscle Tension
___ Numbness
___ Premenstrual Syndrome
___ Seizures
___ Thyroid Problems

Any yes responses, please give date(s) and outcome(s):

_____
_____
_____

III. Current Family Data

Please provide the following family information regarding child's brothers and sisters (include all pregnancies, adoptions, and foster siblings):

First Name-Last Name	Sex	Age	Relationship to child (full, step, half, foster)	Child-Sibling Relationship (positive, neutral, negative, etc.)
1.				
2.				
3.				
4.				
5.				

Parent(s) problem with chemicals? (current/past) ___Yes ___No - If yes, please specify which parent? _____

Type: Alcohol Marijuana Other drugs: _____

Has your child ever experienced a traumatic event? ___Yes ___No

If yes, specify type: ___ Physical Abuse ___ Sexual Abuse ___ Neglect ___ Death of Loved One ___ Car Accident
___ Change/Absence in Care Giver ___ Other: _____

Details: _____

Custody and/or visitation concerns (if applicable):

_____
_____
_____

Does the child have immediate or extended family with a history of mental illness or chemical dependency? ___ Yes ___ No
If yes, please list below:

_____
_____
_____
_____

Do you have a history of suicide in your family? ___Yes ___No

If yes, please list member(s)/relationship to child: _____

CAGE: (To be completed by child ages 12 and up):

Have you ever felt you should cut down on your drinking or drug use? ___Yes ___No

Have people annoyed you by criticizing your drinking or drug use? ___Yes ___No

Have you ever felt bad or guilty about your drinking or drug use? ___Yes ___No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ___Yes ___No

IV. Developmental Issues

Have you ever had concerns about the following issues with this child? (Please circle answer.)

During Pregnancy:

1. Was your pregnancy planned? Yes No
2. Had bleeding during pregnancy? Yes No Unknown
3. Had Toxemia? Yes No Unknown
4. Had to take medications? Yes No Unknown

Specify any medication: _____

5. Got injured or hurt? Yes No Unknown
6. Gained less than 15 lbs? Yes No Unknown

Specify: _____

7. Took narcotic drugs? Yes No Unknown
8. Drank alcohol? Yes No Unknown
9. Had an infection? Yes No Unknown
10. Smoked? Yes No Unknown
11. Length of pregnancy: _____ months
12. Did you experience any trauma during your pregnancy (i.e., loss of housing, violence in a relationship, more than normal level of stress, etc.)? Yes No
13. Other pregnancy problems/illnesses: _____

Birth/Early Infancy:

1. Born prematurely? Yes No Unknown
1. Born with cord around neck? Yes No Unknown
2. Injured during birth? Yes No Unknown
3. Had trouble breathing? Yes No Unknown
4. Turned blue (cyanosis)? Yes No Unknown
5. Was a twin or triplet? Yes No Unknown
6. Had an infection? Yes No Unknown
7. Had seizures (fits, convulsions)? Yes No Unknown
8. Needed oxygen? Yes No Unknown
9. Was very jittery? Yes No Unknown
10. Other: _____

V. School History

1. Present School: _____ Grade: _____
2. Has your child ever repeated a grade? ___Yes ___No If yes, which grade(s): _____
3. Does your child receive special education services? ___Yes ___No
   a. If yes, how does he/she qualify? _____
   b. If no, has your child ever been tested and determined not to need services? ___Yes ___No When _____
4. What grades has your teen generally received? (circle) A B C D F
5. What grades are they currently earning? (circle) A B C D F NA
6. Please describe academic or other problems your teen has in school:

_____

_____

_____

VI. Child Care History

1. Is your child in a child care setting? ___ Yes ___ No

2. In how many child care settings has your child been involved? _____
3. Were there any issues in any child care locations? ___ Yes ___ No

If yes, please explain: _____

VII. Mental Health History

Any previous psychological or psychiatric treatment? ___Yes ___No

Whom/Where _____ When _____

Any previous testing (school/psychological)? ___Yes ___No

Whom/Where _____ When _____

List any medicines previously used for emotional problems, and please note if they were helpful or not:

_____

_____

VIII. Faith/Spirituality History

Please briefly describe your spiritual/faith background and its importance in your life:

_____

_____

Are there any other cultural concerns you have or of which you would like us to be aware?

_____

_____

Please tell us about your family dynamics (i.e., are you a loud and interactive family, or quiet and more reserved, do you enjoy outdoor activities, sports, animals, hunting/fishing, etc.):

_____

_____

IX. Symptom/Problem Checklist

Check any symptom that is a concern. How long has it been a problem?

___ Sleep problems (falling/staying asleep)
___ Lack of interest in activities
___ Unassertive
___ Fatigue/low energy
___ Concentration problems
___ Appetite/weight changes
___ Withdrawal
___ Low self-esteem
___ Forgetful/memory problems
___ Aggressive behavior
___ Can't sit still
___ Few, if any, friends
___ Is picked on/bullied by peers
___ Racing thoughts
___ Excessive worry/fearfulness
___ Fear of being contaminated
___ Anxiety or panic attacks
___ Social fears/shyness

___ Morbid thoughts
___ Suicidal thoughts or threats
___ Suicide plans
___ Mood swings
___ Depression
___ Cries easily/often
___ Changed friends
___ Repeats behaviors over and over
___ Talks excessively/interrupts
___ Irritable
___ Impulsive
___ Difficulty following rules
___ Problems completing school work
___ Compulsive behavior
___ Nightmares
___ Flashbacks
___ Worries about food/weight
___ Resistant to change

___ Constipation
___ Head banging
___ Rocking in bed
___ Temper tantrums
___ Difficulty being comforted/cons
___ Stiffness/rigidity
___ Shyness with strangers
___ Stealing
___ Being destructive (Self/others/objects)
___ Fire setting
___ Hurting others/fighting
___ Discipline problems
___ Short tempered
___ Easily annoyed/annoys others
___ Angry/resentful
___ Lying
___ Trouble with the law
___ Truancy/skipping school

___ Tics
___ Bed-wetting
___ Physical complaints (headaches, stomachaches, etc)
___ Self-injurious behavior (cutting, burning)
___ Extreme reaction to noise/sudden movements
___ School refusal
___ Perfectionism
___ Hurting others sexually
___ Alcohol/drug use
___ Argumentative/defiant
___ Blames others for mistakes
___ Acts as if has no fear

What are your child's strong points and hobbies?

_____

_____

X. Traumatic Events Screening Inventory

Children may experience stressful events, which may affect their health and well-being. Please indicate *if* your child has experienced any of these potentially stressful events by answering the questions below. If the answer is yes, please explain in the area below the question. If the answer is no, please go to the next question. If you have any concerns or comments about any of the questions, we would be happy to talk to you about them. Please **circle** your answers.

1. Has your child ever ***been in*** a serious accident where someone could have been (or actually was) severely injured or died? (i.e., a serious car or bicycle accident, a fall, a fire, an incident where s/he was burned, an actual or near drowning, or a severe sports injury)

   Yes No Unsure

   If yes, please explain: _____

2. Has your child ever been in a serious natural disaster where someone could have been (or actually was) severely inured or died? (i.e., a tornado, hurricane, fire, or earthquake)

   Yes No Unsure

   If yes, please explain: _____

3. Has your child ever experienced the severe illness or injury of someone close to him/her?

   Yes No Unsure

   If yes, please explain: _____

4. Has your child ever experienced the death of someone close to him/her?

   Yes No Unsure

   If yes, please explain: _____

5. Has your child ever undergone any serious medical procedure or had a life threatening illness? Or, been treated by a paramedic, seen in an emergency room, or hospitalized overnight for a medical procedure?

   Yes No Unsure

   If yes, please explain: _____

6. Has your child ever been separated from you or another person who your child depends on for love or security for more than a few days **OR** under very stressful circumstances? (i.e., due to foster care, immigration, war, major illness, or hospitalization)

   Yes No Unsure

   If yes, please explain: _____

7. Has someone close to your child ever attempted suicide or harmed him or herself?

   Yes No Unsure

   If yes, please explain: _____

8. Has someone ever physically assaulted your child (i.e., hitting, pushing, choking, shaking, biting, or burning)? Or, punished your child and caused physical injury or bruises? Or, attacked your child with a gun, knife, or other weapon? (This could be done by someone in the family or by someone in your child's family.)

   Yes No Unsure

   If yes, please explain: _____

9. Has someone ever directly threatened your child with serious physical harm?

   Yes No Unsure

   If yes, please explain: _____

10. Has someone ever mugged or tried to steal from your child? Or, has your child been present when a family member, other caregiver, or friend was mugged?

    Yes No Unsure

    If yes, please explain: _____

11. Has anyone ever kidnapped your child (including a parent or relative)? Or, has anyone ever kidnapped someone close to your child?

    Yes No Unsure

    If yes, please explain: _____

12. Has your child ever been attacked by a dog or other animal?

    Yes No Unsure

    If yes, please explain: _____

13. Has your child ever seen or heard about people ***in your family*** physically fighting, hitting, slapping, kicking, or pushing each other? Or, shooting with a gun, stabbing, or using any other kind of dangerous weapon?

    Yes No Unsure

    If yes, please explain: _____

14. Has your child ever seen or heard people ***in your family*** threaten to seriously harm each other?

    Yes No Unsure

    If yes, please explain: _____

15. Has your child ever known or seen that a family member was arrested, jailed, imprisoned, or taken away (i.e., by police, soldiers, or other authorities)?

    Yes No Unsure

    If yes, please explain: _____

16. Has your child ever seen or heard people outside your family fighting, hitting, pushing, or attacking each other? Or, seen or heard about violence such as beatings, shootings, or muggings, which occurred in settings that are important to your child, such as school, your neighborhood, or the neighborhood of someone important to your child?

    Yes No Unsure

    If yes, please explain: _____

17. Has your child ever been directly exposed to war, armed conflict, or terrorism?

    Yes No Unsure

    If yes, please explain: _____

18. Has your child ever seen or heard anything regarding acts of war or terrorism, on the television or radio?

    Yes No Unsure

If yes, please explain: _____

19. Has anyone ever **made** your child see or do something sexual (i.e., touching in a sexual way, exposing self in front of the child, engaging in sexual intercourse)?

    Yes No Unsure

    If yes, please explain: _____

20. Has your child ever been present when someone was being forced to engage in any sort of sexual activity?

    Yes No Unsure

    If yes, please explain: _____

21. Has your child ever repeatedly been told s/he was no good, yelled at in a scary way, or had someone threaten to abandon, leave or send him/her away?

    Yes No Unsure

    If yes, please explain: _____

22. Has your child ever gone through a period when s/he lacked appropriate care (i.e., not having enough to eat or drink, lacking shelter, being left alone when s/he was too young to care for herself/himself, or being left with a caregiver who was abusing drugs)? Yes No Unsure

    If yes, please explain: _____

23. Have there been other stressful things which have happened to your child?

    Yes No Unsure

    If yes, please explain: _____

Signature of person completing form/relationship to client:

_____/_____ Date ____/____/____

Name Relationship