Lighthouse Child & Family Services

Child 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:

_____

_____

_____

What is your child's strong points and hobbies?

_____

_____

II. 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.				

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: _____

III. 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:

_____

IV: Trauma

Has your child experienced any of the following? If checked, please give dates and more details below.

___Death of a Parent
___ Legal Difficulties
___ Witness to Domestic Violence
___ Frightening Experience
___ Parental Separation/Divorce
___ Accident/Serious Injury
___ Death of Someone Very Close
___ Death or Loss of a Pet
___ Sexual Abuse
___ Physical Abuse
___ Emotional/Verbal Abuse
___ Prolonged Separation from Parent

_____
_____
_____
_____
_____

V. 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:

_____
_____

Does your child have any infectious diseases? ___ Yes ___ No – If yes, please describe disease and medical precautions taken:

_____
_____

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
___ Asthma
___ Attention Deficit Disorder
___ Autism
___ Brain Injury
___ Breathing Problems
___ Cancer
___ Chronic Fatigue Syndrome
___ Chronic Pain
___ Diabetes
___ Eating Disorder
___ Fibromyalgia
___ Gastrointestinal Problems
___ Headaches
___ Heart Problems
___ High Blood Pressure
___ High Cholesterol
___ Infectious Disease
___ Menopause
___ Lyme Disease
___ Neurological Problems
___ Muscle Tension
___ Pain in Chest
___ Numbness
___ Postpartum Depression
___ Premenstrual Syndrome
___ Stomach Aches
___ Seizures
___ Ulcers
___ Thyroid Problems
___ Other (please list)
_____

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

_____
_____

_____

VI: 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: _____

VII: Substance Use:

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

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

Type: Alcohol Marijuana Other drugs: _____

VIII. 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 child generally received? (circle) A B C D F
5. Do you have concerns about attendance? ___ Yes ___ No
6. Please describe academic or other problems your child has in school:

_____
_____
_____

IX. 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: _____

X. 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.):

_____

_____

XI. Symptom/Problem Checklist

Check any symptom that is a concern.

Behavioral Issues

___ Aggression
___ Agitation
___ Animal abuse
___ Avoidance
___ Belligerence
___ Binge eating
___ Bullying
___ Compulsive
___ Defiant
___ Disinhibition
___ Exaggerated startle response
___ Fire setting
___ Hyperactivity
___ Hypervigilance
___ Impulsiveness
___ Isolative activities
___ Night walking
___ Overeating
___ Over-extending
___ Pleasure seeking
___ Purging
___ Refusing to eat
___ Risk taking
___ Task initiation
___ Thrill seeking
___ Withdrawing

Interpersonal Issues

___ Being misunderstood
___ Communication difficulties
___ Difficulty following directions
___ Fighting
___ Grandiosity
___ Lack of social resources
___ Low self-esteem
___ Sexual difficulties
___ Sexual disinterest
___ Social awareness difficulties
___ Social communication challenges
___ Social motivation issues

Physical Issues

___ Ambulation difficulties
___ Balance problems
___ Being overweight
___ Being underweight
___ Bumping into things
___ Dizziness
___ Excessive fatigue
___ Fine motor control difficulties
___ GI problems
___ Headaches
___ Increased heart rate/palpitations
___ Muscle weakness
___ Nausea/vomiting
___ Pain problems
___ Psychomotor retardation
___ Rapid breathing
___ Repetitive movements
___ Rocking
___ Sensory avoidance
___ Sensory sensitivity
___ Shortness of breath
___ Sleep too little
___ Sleep too much
___ Stomach aches
___ Sweating
___ Tics
___ Tremors
___ Weight gain
___ Weight loss
___ Visual disturbances

Chem. Dependency

___ Active Use
___ Cravings/Urges
___ Recently quit
___ Tolerance
___ Withdrawal symptoms

Emotional Issues

___ Anger issues
___ Anxious/Nervous
___ Apathy
___ Being easily annoyed
___ Boredom
___ Confused
___ Depression
___ Embarrassment
___ Feeling guilty
___ Feeling shame
___ Hard time coping
___ Helplessness
___ Hopelessness
___ Humiliation
___ Insecurity
___ Irritability
___ Loneliness
___ Panicky feelings
___ Powerlessness
___ Problems with jealousy
___ Sadness
___ Scared/fearful
___ Shy
___ Stressed
___ Worried

Safety/security

___ Agoraphobia
___ Being bullied
___ Being stalked
___ Being threatened
___ Having experienced trauma
___ Homicidal ideation
___ Previous suicide attempts
___ Self-harm: burning
___ Self-harm: cutting
___ Self-harm: head banging
___ Self-harm: scratching
___ Suicidal ideation

Cognitive Issues

___ Amnesia
___ Aphasia
___ Decision-making difficulties
___ Difficulty sustaining focus
___ Easily distracted
___ Irrational thinking
___ Loss of cognitive skills
___ Memory problems
___ Nightmares/night terrors
___ Obsessive thinking
___ Organizing difficulties
___ Poor judgement
___ Problem-solving difficulties
___ Racing thoughts
___ Rigidity
___ Sequencing problems
___ Tangential thinking
___ Tracking/attention problems

Family/Couples

___ Abusing other(s)
___ Adoption difficulties
___ Arguing/fighting
___ Being abused
___ Divorce
___ Having an affair
___ Intimacy problems
___ Parenting problems
___ Partner infidelity
___ Separation or estrangement