



Lighthouse Child & Family Services

CHILD INFORMATION FORM

GENERAL INFORMATION

Child's Full Legal Name: _____ Preferred Name: _____

DOB: ____/____/____ Age: ____ Sex: ____

Referred to LCFS by: _____

Mother's Name: _____ Phone Number: _____

Father's Name: _____ Phone Number: _____

Parental Relationship Status: Married Separated Divorced Never Married

Parental/Child Relationship: Biological
 Step
 Adoptive – Child adopted at age: _____
 Foster – Child in Foster Care since: _____

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

Primary reason(s) you are concerned about your child:

What are your child's strong points? _____

What are your child's hobbies? _____

Please provide the following family information regarding your child's brothers and sisters (include all pregnancies, adoptions, and foster siblings and use a separate sheet of paper if necessary):

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

Custody and/or visitation concerns (if applicable):

Describe your family dynamics (i.e., the family is loud and interactive, quiet and more reserved, enjoys outdoor activities, etc.):

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

MENTAL HEALTH HISTORY

Does the child have immediate or extended family with a history of mental illness or substance use?

Yes No If yes, please explain: _____

Is there a history of suicide in your family?

Yes No If yes, what family member in relation to your child? _____

Any previous psychological or psychiatric treatment?

Yes No If yes, with whom, where and when: _____

Any previous testing (school/psychological)?

Yes No If yes, with whom, where and when: _____

List any medications previously used for emotional problems and if they seemed helpful or not: _____

TRAUMA HISTORY

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

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

If checked, please provide details/dates:

MEDICAL HISTORY

Name and city of child’s physician/medical group: _____

Last appointment with physician: _____ / _____ / _____

Date of last physical: _____ / _____ / _____

Does your child have a history of serious illness, injuries, handicaps, or hospitalizations?

Yes No If yes, please explain: _____

Does your child have any infectious diseases?

Yes No If yes, list disease and medical precautions taken: _____

Are there any major medical conditions in the child’s immediate family?

Yes No If yes, list the condition and the relationship of the family member to the child: _____

Please list all prescribed medications 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?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Infection Disease | <input type="checkbox"/> Premenstrual Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stomach Aches |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Menopause | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cancer, type: _____ | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Numbness | |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pain in Chest | |
| | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Postpartum Depression | |

If checked, please provide details/dates: _____

DEVELOPMENTAL ISSUES (during pregnancy, the child's birth and early infancy)

1. During Pregnancy

- Length of Pregnancy: _____ Months
- Was the pregnancy planned? Yes No
- Was there bleeding? Yes No
- Did you have Pre-eclampsia? Yes No
- Were you on any medications? Yes No If yes, please list: _____
- Were you injured/hurt? Yes No If yes, please explain: _____
- Did you gain less than 15 pounds? Yes No
- Did you take any narcotic/street drugs? Yes No
- Did you drink alcohol? Yes No If yes, how much: _____
- Did you smoke? Yes No If yes, how much: _____
- Did you have any infection(s)? Yes No If yes, please explain: _____
- Did you experience any Trauma? Yes No If yes, please explain (loss of housing, domestic violence, etc.): _____
- _____

2. During the Child's Birth/Early Infancy

- Was the baby born prematurely? Yes No If yes, at how many weeks: _____
- Was the ambilocal cord wrapped around the baby's neck? Yes No
- Did an injury occur during birth? Yes No If yes, please explain: _____
- Did the baby turn blue (Cyanosis)? Yes No
- Was the baby a twin/triplet/etc.? Yes No
- Did the baby have any infection(s)? Yes No If yes, please explain: _____
- Did the baby have seizures? Yes No
- Did the baby need oxygen? Yes No
- Was the baby very jittery? Yes No

SUBSTANCE USE HISTORY

CAGE-AID (***To be completed by children 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
- Have your parents had a current or past problem with alcohol/drugs? Yes No
- If yes, which parent(s) and type of substance? _____

SCHOOL HISTORY

Current School: _____

Grade: _____

- Has your child ever repeated a grade? Yes No If yes, which grade(s): _____
- Do you have attendance concerns? Yes No
- Do you have concerns about your child's grades? Yes No
- What grades to they generally receive? (circle) A B C D F
- Does your child receive Special Education services? Yes, they qualify by: _____
- No, they have not been tested/determined to need services
- No, they have been tested and determined not to need services
- Last tested (month/year): _____
- Do you have concerns about any other academic or general problems your child has in school? Yes No If yes, please list: _____

CHILD CARE HISTORY

- Is your child currently in a childcare setting? Yes No
- Have they been involved in multiple settings? Yes No If yes, how many total? _____
- Have there been any issues at any of the settings? Yes No If yes, please explain: _____

FAITH/SPIRITUALITY HISTORY

If applicable, please briefly describe your spiritual/faith background and its importance in your life: _____

SYMPTOM/PROBLEM CHECKLIST

Check all symptoms your child is experiencing that are a concern to you.

1. Behavioral Issues

- Aggression
- Agitation
- Animal Abuse
- Avoidance
- Belligerence
- Binge Eating
- Bullying
- Compulsiveness
- Defiance
- Disinhibition
- Exaggerated Startle Response
- Fire Setting
- Hyperactivity
- Hypervigilance
- Impulsiveness
- Isolative Activities
- Night Walking
- Over-extending
- Pleasure Seeking
- Purging
- Refusing to Eat
- Task Initiation
- Thrill Seeking
- Withdrawing

2. Cognitive Issues

- Amnesia
- Aphasia
- Difficulty Making Decisions
- Difficulty Focusing
- Difficulty Organizing
- Difficulty Problem-solving
- Easily Distracted
- Irrational Thinking
- Loss of Cognitive Skills
- Memory Problems
- Nightmares/terrors
- Obsessive Thinking
- Poor Judgement
- Racing Thoughts
- Rigidity
- Sequencing Problems
- Tangential Thinking
- Tracking/Attention Problems

3. Emotional Issues

- Anger Issues
- Anxious/Nervous
- Apathy
- Boredom
- Confusion
- Depression
- Difficulty Coping
- Easily Annoyed
- Embarrassment
- Feeling Guilty
- Feeling Shame
- Helplessness
- Hopelessness
- Humiliation
- Insecurities
- Irritability Loneliness
- Jealousy Problems
- Panicky Feelings
- Powerlessness
- Sadness
- Scared/Fearful
- Shy
- Stressed
- Worried

4. Family/Couple Issues

- Abusing Others
- Adoption Difficulties
- Arguing/Fighting
- Being Abused
- Divorce
- Having an affair
- Intimacy Problems
- Parenting Problems
- Partner Infidelity
- Separation or Estrangement

5. Interpersonal Issues

- Being Misunderstood
- Difficulty Communicating
- 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

6. Physical Issues

- Ambulation Difficulties
- Balance Problems
- Being Overweight
- Being Underweight
- Bumping Into Things
- Dizziness
- Excessive Fatigue
- Excessive Sweating
- Fine Motor Control Difficulties
- Gastrointestinal Problems
- Headaches/Migraines
- Heart Problems
- Muscle Weakness
- Nausea/Vomiting
- Psychomotor Retardation
- Rapid Breathing
- Repetitive Movements
- Rocking
- Sensory Avoidance
- Sensory Sensitivity
- Shortness of Breath
- Sleeping too little
- Sleeping too much
- Stomach Aches
- Tremors
- Weight Gain
- Weight Loss
- Visual Disturbances

7. Safety/Security Issues

- Agoraphobia
- Being Bullied
- Being Stalked
- Being Threatened
- Homicidal Ideation
- Previous Suicide Attempts
- Self-harm: Burning
- Self-harm: Cutting
- Self-harm: Head Banging
- Self-Harm: Scratching
- Suicidal Ideation
- Trauma Experience

8. Substance Use Issues

- Active Use
- Cravings/Urges
- Recently Quite
- Tolerance
- Withdrawal Symptoms