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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?

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

Does the client currently use or have a history of chemical use (including tobacco)? ☐ Yes ☐ No

Is there a history of drug/alcohol use on either side of the family? ☐ Yes ☐ No

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