



**Client Information Form - Child**  
Clinical Services

**Child's Information**

Today's Date: \_\_\_\_\_

Name (Last, First, Middle Initial): \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Gender:  Male  Female

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Age: \_\_\_\_\_

Ethnicity:  1- Caucasian

3 - Hispanic

5 - Asian

2 - African American

4 - Native American

6 - Other

Does child attend school or preschool?  Yes  No

Current grade: \_\_\_\_\_

Name of school: \_\_\_\_\_

Name of teacher: \_\_\_\_\_

Any concerns regarding school performance?

Yes  No (If yes, please explain)

\_\_\_\_\_

Any concerns about relationships with:

Teachers  Yes  No

Peers  Yes  No

Friends  Yes  No

Payor Source:  Idaho Medicaid  Dept Health & Welfare  Private Pay / Insurance

If Medicaid, name of Healthy Connections Provider: \_\_\_\_\_

If referred by the Dept of Health & Welfare, name of assigned case manager: \_\_\_\_\_

If private pay / insurance, name of insurance company: \_\_\_\_\_

Name of child's regular physician: \_\_\_\_\_

Special Needs:  Blind/Visually Impaired

Deaf/Hearing Impaired

Developmentally Delayed

Physically Handicapped

Other \_\_\_\_\_

**Parent/Caregiver Information**

Name (Last, First, Middle Initial): \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Annual Household Income Level: (statistical purposes only)

< \$8,000

\$12,001 - \$17,000

\$24,001 - \$30,000

\$8,001 - \$12,000

\$17,001 - \$24,000

> \$30,001

## Alleged Abuse Information

Type of Abuse:  Child Victim/Physical Abuse  Child Victim/Sexual Abuse  
 Child Victim/Drug Endangered  Child Victim/Neglect  
 Other \_\_\_\_\_

The abuse was:  In-home (alleged offender lives in child's home)  
 Out-of-home (alleged offender does not live in child's home)

Name of Alleged Offender: \_\_\_\_\_ Age of Offender: \_\_\_\_\_

Offender's Relationship to Child: \_\_\_\_\_

Please provide your understanding of the alleged abuse:

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Has your child shown any changes in behavior since the alleged abuse?  Yes  No

If yes, please explain: \_\_\_\_\_

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Is your child currently being seen by a counselor or therapist?  Yes  No

If yes, name of counselor or agency: \_\_\_\_\_

Additional comments or concerns: \_\_\_\_\_

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## Health History/Medical Concerns

Please list any current or past health/medical concerns you feel we need to be aware of.

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## Major Illnesses / Surgeries

Yes  No  
If yes, please list below:

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## Medication(s)

Is your child currently taking any medications?

Yes  No

If yes, please list what they are currently taking and the conditions being treated:

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## Allergies

Does your child have any food or medication allergies?

Yes  No

If yes, please list below:

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## Sleep Habits

Hours per night: \_\_\_\_\_

Naps (number & length): \_\_\_\_\_

Any sleep problems?  Yes  No

If yes, please explain:

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## Exposure / Habits

Any concerns about lead exposure (old home/plumbing/peeling paint)?  Yes  No

Do any household members smoke?  Yes  No

Television – hours per day: \_\_\_\_\_

Computers – hours per day: \_\_\_\_\_

Video games – hours per day: \_\_\_\_\_

## Development

Are you aware of any developmental difficulties your child had or currently has?  Yes  No

If yes, please describe:

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## Family History

Please indicate family members (parent, sibling, grandparent, etc.) with any of the following conditions:

- |   |  |
|---|--|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> High cholesterol    |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Suicide             |
| <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Bleeding disorder   |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Bipolar disorder    |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Drug Abuse          |

## Social History

Are child's parents:  Married  Unmarried  Divorced  Separated

If divorced or separated, when? \_\_\_\_\_

Custody arrangements: \_\_\_\_\_

Mother's Occupation/Employer: \_\_\_\_\_

Father's Occupation/Employer: \_\_\_\_\_

Child care situation:

- Parents
- Others (who and how often) \_\_\_\_\_

Do any of the following concern you about your child?

- Alcohol use
- Tobacco use
- Sexual behavior
- Aggressive behavior
- Other \_\_\_\_\_

Does your child participate in any type of organized sport or physical activity?  Yes  No

What and how often? \_\_\_\_\_

Does your child enjoy any particular hobbies?  Yes  No

Please describe your child's personality: \_\_\_\_\_

How does your child comfort him/herself? \_\_\_\_\_

How does your child express anger/frustration: \_\_\_\_\_

What are your child's fears? \_\_\_\_\_

What concerns you most about this child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_