The Steven A. Cohen Military Family Clinic at Easterseals

OFFICE USE ONLY: V4 2019

Date: _____

ID#: _____

Staff member: _____

Personal Information

Name of child: _____
Last *First* *M.I.*

Does child prefer a different name? (nickname, etc) If yes, what is it? _____

Childs Date of Birth: _____ Age: _____

Child's Gender:

Name of person completing questionnaire: _____

Relationship to child: _____

What is your custodial relationship to this child? _____

*** If Joint Custody or Shared Legal Custody both parties must sign Clinic Informed Consent and Client Rights. If Sole Custody please provide custody agreement information to the clinic. ****

Parent/Guardian's Address

_____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

_____
County

Parent / Guardians Mobile phone? Mobile Provider? Ok to leave a Message?

Mobile Phone: _____ _____

Alternate Phone: _____ _____

Evening Phone: _____ _____

Email Address: _____

Okay to email? *Please note, for your privacy minimal information will be sent electronically. (Example, no names will be sent just dates, time and logistical information)*

Preferred method of contact? ☐ Phone Call ☐ Email ☐ Other: _____

Additional Parent / Legal Guardians contact information:

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

_____
County

Relationship to Client:_____Gender: _____

Mobile phone? Mobile Provider? Ok to leave a Message?

Mobile Phone: _____ _____

Alternate Phone: _____ _____

Child's address (if different from parent / Guardian)

_____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

_____
County

Childs Phone number if different from parent /guardians: _____

Childs Email (if applicable): _____

Preferred Language: _____ Secondary Language: _____

Is child currently covered for health insurance? ☐ Whos insurance?_____

If yes, what type of health insurance? _____

If Tricare, what is the childs DOD Benefits ID Number: _____

Childs Social Security Number: _____

Parent / Guardians Social Security Number: _____

Child's Race/Ethnicity: ☐

Other: _____

Any barriers to care or special accommodations needed (language, physical, cultural, spiritual or otherwise) ?

_____

Emergency Contact Information

***** Please Note that both Parents / Guardians will be included in record as an Emergency Contact. Please Add additional Emergency contact if desired. *****

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *Zip Code*

_____
County

Relationship to Client:_____Gender: _____

Mobile phone? Mobile Provider? Ok to leave a Message?

Mobile Phone: _____ _____

Alternate Phone: _____ _____

Can your emergency contact pick your child up from an appointment?

Military Background

Complete using a Military Family member's information.
Not all Military Family members need to be identified, although their service is appreciated.

Which Family Member served in the Military? _____ Branch: _____

Were they a post 9/11 Veteran? (Served on or after 9/11/2001)

Military status: ☐ Other: _____

Enrolled in VA Health care? ☐ if yes, where? _____

Did they receive a disability rating through the VA? if yes, what is the percentage? _____

Are you a Military Caregiver (a military caregiver is a family member, friend or acquaintance who provides a broad range of care and assistance for, or manages the care of, a current or former military service member with a disabling physical or mental injury or illness regardless of official designation) ☐

Home Information

Who currently resides in your home?

Name Age & Gender Relationship to Client

Are there any firearms in your home? ☐

If yes, please provide more information (if they are locked, who has access, etc): _____

Medical History

Name of Childs Primary Care
Physician and Clinic: _____

Date of last physical exam? _____

Is your child up to date on immunizations? ☐

Any chronic illnesses or current physical concerns? ☐

If yes please explain: _____

Any speech, hearing or visual difficulties? ☐

Name of other Medical providers, clinic and specialty. (Chiropractic, Rheumatology, etc) :

What is your child's current weight? _____ What is your child's current height? _____

During pregnancy with your child did the mother use tobacco, alcohol or illicit drugs? ☐

Has your child ever been exposed to tobacco, alcohol or drug use? ☐

Does your child use tobacco, alcohol or any other substances? ☐

If yes or unknown, please explain: _____

Does your child have any medication allergies? ☐

Please explain: _____

Is your child taking any prescription, non-prescription medications or supplements? ☐

If yes, what are your child's current medications? (Please provide medication name, dose and frequency)

_____

_____

_____

_____

_____

_____

Do you feel the medications are effective? ☐

Please explain: _____

Any concern with side effects or adverse reactions? ☐

Please explain: _____

In the past 2 weeks, were there any changes in medication? ☐

If YES, what were the changes? _____

How often does your child miss a dose of their medications? _____

Do you have a hard time getting your child to take their medications? ☐

Social & School Background

What school does your child attend? _____

_____
Street Address

_____
City *State* *Zip Code*

_____
County

What grade is your child currently in? _____ Has your child ever been held back? _____

Has your child ever received any special education services?

If yes, please explain: _____

Has your child ever been suspended? _____

Has your child had any legal issues? _____

Mental Health History

Has your child ever received counseling, psychological, or psychiatric treatment? ☐

Is your child currently receiving counseling, psychological, or psychiatric treatment? ☐

If currently in mental health treatment, would you be okay with us contacting your other mental health provider for continuity of care? ☐ (note that a release of information is required before we will contact.)

Please list below all current or past mental health care your child has received starting with the most recent.

Type of treatment (Counseling, inpatient, Medication only, etc)	Type of problem	approx. Dates/years	Where did you receive treatment?

Were you satisfied with any mental health treatment your child has received?

What have you found helpful in past mental healthcare experiences?_____

_____

Is there any family history of mental health concerns (e.g. depression?)

If yes, please explain: _____

Does your child have any issues eating or with their body image?

If yes, please explain: _____

Reason for Visit

What is the reason for your childs visit today? _____

_____

_____

_____

What type(s) of services are you interested in? *(Select all that apply)*

☐ Individual therapy (child) ☐ Parent consultation ☐ Family therapy ☐ Non-mental health services (e.g. help with housing, Employment)

Other: _____

How did you learn about this clinic? (Who, where, when?) _____

_____

_____