childguidance &familysolutions

CENTRAL OFFICE
18 N. Forge Street
Akron, OH 44304-1317
Phone: 330-762-0591
Fax: 330-762-2242
www.cgfs.org

Thank you for your interest in receiving services here at Child Guidance & Family Solutions (CG&FS). We look forward to working with your family. Below is some additional information about your first appointment that we hope you will find helpful:

- The initial appointment will be for the parent/legal guardian and child. If you are not the biological parent and you are the legal guardian, please bring your court approved guardianship papers so we can make a copy for our records. If someone, other than the biological parent or legal guardian brings the child to the first appointment, the appointment will be rescheduled.
- Please bring with you a copy of the completed client questionnaire to the initial appointment. If you forget or are unable to complete it, we will ask you to stay after your appointment to complete the client questionnaire. This information is very helpful to the therapist you will be seeing.
- The initial appointment will last approximately one hour with the CG&FS therapist. The therapist has reserved this appointment time for you. If you need to cancel, please contact our Admissions Department as soon as possible to discuss rescheduling.
- A financial interview will be conducted by our Medical Records Staff before you meet with the therapist. At that interview, we ask that you bring all insurance cards you have to be copied for our records and documentation of household income for sliding scale fee (see below). We accept Ohio Medicaid and multiple commercial insurance plans. If you have questions about your benefits you can contact your insurance company or our billing department (330-794-4254).

In addition to accepting Ohio Medicaid and commercial insurance, pending your eligibility (requirements below), CG&FS can also offer Summit County residents the ADM Board sliding scale fee. In order to establish a sliding scale fee CG&FS must verify your residency in Summit County by using both the address and the client's social security number. The provider must also be contracted with the commercial insurance plan or they will need to be referred to a network provider. Proof of household income must also be provided for verification. The household income (guidelines as outlined by the Summit County ADM Board) is based on the income of either the individual or family including; gross salary/wages (pay stubs, tax forms 1040, Schedule C), Social Security benefits, dividends, interest, pensions, annuities, unemployment compensation, worker's compensation, alimony, child support, strike benefits, trusts, inheritance, SSI or other public assistance programs. The determination of whether an asset is a countable resource shall be based upon requirements applicable to Medicaid eligibility.

For additional information, please visit the CG&FS agency website at www.cgfs.org or call our Admissions Department at 330-762-0591 if you have any questions and we will be happy to assist you.

FRONT STREET
2100 Front Street Mall
Cuyahoga Falls, OH 44221-3220
330-928-2042

NORTH SUMMIT
2305 E. Aurora Road A-12
Twinsburg, OH 44087-1940
330-425-7111 Akron: 330-798-8010

SOUTHEAST SUMMIT
87 N. Canton Road
Akron, OH 44305-3838
330-733-7993

SOUTHWEST SUMMIT
524 W. Park Avenue
Barberton, OH 44203-2516
330-753-1096

FISCAL
87 N. Canton Road
Akron, OH 44305-3838
330-794-4254

DEVELOPMENT
18 N. Forge Street
Akron, OH 44304-1317
330-384-2882

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CLIENT QUESTIONNAIRE (STANDARD)

Client # ________

Welcome. Thank you for choosing Child Guidance and Family Solutions. Please complete all the information below. It is valuable and needed to better understand your family dynamics as well as to meet the standards of our accrediting bodies.

MINOR INFORMATION

Last Name:______________________ First Name:________________ Middle Initial:_____

Name called by:______________ Date of Birth:____________ Sex: ❑ F ❑ M

What is your child's current height and weight? Height ________ Weight________ Does minor smoke: ❑ Yes ❑No

MINOR'S SOCIAL SECURITY NUMBER (required)______________________________

Home Address:______________________________ City:__________ Zip (+4):__________

County of Residence: ______________ School and current grade:______________________

Primary Language: ❑ English ❑ Spanish ❑ Other ______________________

Race: ❑ Alaskan Native ❑ Native American ❑ Asian ❑ Black/African American ❑ Pacific Islander/Hawaiian ❑ Two or more races ❑ Unknown ❑ White/Caucasian

Ethnic Origin: ❑ Not of Hispanic Origin ❑ Cuban ❑ Mexican /Mexican-American ❑ Other Hispanic ❑ Puerto Rican ❑ Unknown

Please bring with you copy of custody or legal guardianship papers if applicable

CONTACT #1 INFORMATION

Last Name:____________________ First Name:______________ Living with client? ❑ Yes ❑ No

Relationship to minor: ❑ Mother ❑ Father ❑ Step-Mother ❑ Step- Father ❑ Grandmother ❑ Grandfather ❑ Aunt ❑ Uncle ❑ Guardian

Home Phone: ______________ Work Phone: ________________ Cell Phone: ______________

Preferred Phone: ❑ Home ❑ Work ❑ Cell May we leave a message at your preferred method of contact? ❑ Yes ❑ No

CONTACT #2 INFORMATION

Last Name:____________________ First Name:______________ Living with client? ❑ Yes ❑ No

Relationship to minor: ❑ Mother ❑ Father ❑ Step-Mother ❑ Step- Father ❑ Grandmother ❑ Grandfather ❑ Aunt ❑ Uncle ❑ Guardian

Home Phone: ______________ Work Phone: ________________ Cell Phone:______________

Preferred Phone: ❑ Home ❑ Work ❑ Cell May we leave a message at your preferred method of contact? ❑ Yes ❑ No

If Contact 1 and Contact 2 are not the biological/adoptive parents' names, what are their names?

Mother:__________________________ Father:__________________________

Client Name & Number ____________________

Other adults currently living in the same household as minor:

Full Name	Date of Birth	Relationship (to minor)	Last Grade Completed

Other children in the home:

Full Name	Date of Birth	Relationship (to minor)

Are there any members of your household receiving services from Child Guidance & Family Solutions? ❑ Yes ❑ No

Who referred you to Child Guidance & Family Solutions?

❑ School Please list: ____________________ ❑ Employer/EAP Provider ❑ Insurance Panel Provider List

❑ Primary Care MD/DO ❑ Private Mental Health Professional ❑ Mental Health Agency

❑ Akron Children's Hospital ❑ Akron Children's Hospital PHP/IOP/PIRC ❑ Hospital

❑ Family/Relative ❑ Friend ❑ Other family member is/was a client ❑ Was a client here before

❑ Summit County Children's Services ❑ Out of county Children's Services ❑ Juvenile Court ❑ Police/Diversion

❑ Child Guidance & Family Solutions Employee ❑ Other ____________________

PRIMARY INSURANCE INFORMATION: Bring Copy of Current Insurance Card(s)

Insurance Company: ____________________

ID# ____________________ Group/Contract # ____________________

Policy Holder Name: ____________________ Policy Holder Birthdate: ____________________

Relationship to the Minor: ❑ Mother ❑ Father ❑ Step-Parent ❑ Other: ____________________

Policy Holder Address (if different from minor's): ____________________

City: ____________________ State: __________ Zip: __________

Policy Holder Employer: ____________________ Policy Holder SSN#: ____________________

SECONDARY INSURANCE INFORMATION: Bring Copy of Current Insurance Card(s)

Insurance Company: ____________________

ID# ____________________ Group/Contract # ____________________

Policy Holder Name: ____________________ Policy Holder Birthdate: ____________________

Relationship to the Minor: ❑ Mother ❑ Father ❑ Step-Parent ❑ Other: ____________________

Policy Holder Address (if different from minor's): ____________________

City: ____________________ State: __________ Zip: __________

Policy Holder Employer: ____________________ Policy Holder SSN#: ____________________

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Client Name & Number____________________

How many homes, since birth, has your child lived in?____________

Of the adult(s) who are head of this household, are there children from either this or previous marriage(s)/relationship(s) who live elsewhere? ☐ Yes ☐ No

If yes, please provide the following information:

Full Name	Age	CHILD OF: Mother	Father	Other	LIVING WITH: Mother	Father	On Own	Other

SCHOOL RELATED INFORMATION

Does your child receive any special educational services (e.g. special class placement, tutoring, speech therapy)? ☐ Yes ☐ No

If yes, please specify which service(s)?____________________

____

Has your child ever repeated a grade? ☐ Yes ☐ No

If yes, which grade(s)?____________

Does/did your child attend a preschool program? ☐ Yes ☐ No

If yes, please provide the following information:

Special Educational program provided by local public school because of qualifying condition (e.g. children with severe emotional and/or behavioral problems)? ☐ Yes ☐ No If yes, age(s) of child when attended:____________

Head Start? ☐ Yes ☐ No If yes, age(s) of child when attended:____________

Other: (specify)____________ Age of child during year(s) attended____________

How would you rate your child's attitude about going to school?

1 2 3 4 5

He/she hates school; it is a daily struggle getting him/her to attend — Child enjoys school greatly; looks forward to attending every day

How would you rate your child's behavior at school?

1 2 3 4 5

There are major behavior problems almost every day — He/she never has any behavior problems at school

How would you rate how your child does with his/her schoolwork?

1 2 3 4 5

There are major problems in all subjects; grades are consistently "D's and F's" — Grades in all subjects are consistently "A's"

Approximately how many days of school did your child miss last year for any reason?

DAYS 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 OTHER ________

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Client Name & Number ____________________

MINOR'S MEDICAL HISTORY

Name of family physician/pediatrician, or medical clinic where child receives medical care: ____________________

Date of child's last medical examination (for any reason): ____________________

Are immunizations complete and up to date? ☐ Yes ☐ No

Does your child have allergies? ☐ Yes ☐ No

If yes, please list and describe reaction:

ALLERGY	REACTION(S)				
________	☐ Rash	☐ Cough	☐ Sneezing	☐ Headache	☐ Other: ________
________	☐ Rash	☐ Cough	☐ Sneezing	☐ Headache	☐ Other: ________
________	☐ Rash	☐ Cough	☐ Sneezing	☐ Headache	☐ Other: ________
________	☐ Rash	☐ Cough	☐ Sneezing	☐ Headache	☐ Other: ________

Please describe any serious illnesses, injuries, operations and/or hospitalizations your child has experienced since birth (Do not include hospitalizations for psychiatric/emotional/behavioral reasons):

Illness, Operation, or Injury	Age of Child at the Time	If hospitalized, name of hospital and city

Has your child ever been hospitalized for psychiatric/emotional/behavioral reasons? ☐ Yes ☐ No

If yes, provide the following information:

Date of Admission (mo/yr)	How Long in the Hospital?	Name of Hospital/City	Treating Doctor

Is your child currently taking any medication of any kind, prescribed or not? ☐ Yes ☐ No

If yes, please provide the following information:

Name of medication	Reason for medication	How often each day?	For how long has she/he been taking it?

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Client Name & Number______________________

Please check any of the following symptoms, not already noted, that your child has experienced over the **last three months**:

☐	Visual problems	☐	Unusual tiredness	☐	Frequent coughing	☐	Frequent infections
☐	Hearing loss	☐	Breathing problems	☐	Bone/joint pain	☐	Soiling
☐	Appetite problems	☐	Nosebleeds	☐	Back pain	☐	Daytime wetting
☐	Sleeping problems	☐	Headaches	☐	Diarrhea	☐	Bedwetting
☐	High fevers	☐	Chest pains	☐	Constipation	☐	Frequent urination
☐	Fainting spells/blackouts	☐	Abdominal pain	☐	Nausea	☐	Menstrual pain
☐	Sore throat	☐	Dental problems	☐	Vomiting	☐	Other

NUTRITION

Does your child eat a nutritionally adequate diet? ☐ Yes ☐ No

If no, what concerns do you have about your child's diet?______________________

____

Does your child take multiple vitamins? ☐ Yes ☐ No

Is your child on a special diet? ☐ Yes ☐ No

If yes, what diet and are you comfortable monitoring it?______________________

____

Does your child eat non-food items (e.g. dirt, chalk, rocks, paint, etc.)? ☐ Yes ☐ No

If yes, please explain:______________________

____

Has your child experienced any unplanned or unusual weight loss or weight gain? ☐ Yes ☐ No

The following might be considered "unusual" weight loss:
Young children: 2 pounds in 3 months or 5 pounds in 6 months
Teens: 5 pounds in 1 month or 10 pounds in 6 months

If yes, has your child experienced a recent illness or taken medications? ☐ Yes ☐ No

If yes, what illness or medications: ______________________

____

PREGNANCY AND BIRTH CIRCUMSTANCES

Did the child's mother use any of the following during pregnancy?

Cigarettes	☐ Yes	☐ No	☐ Unsure	
Alcohol	☐ Yes	☐ No	☐ Unsure	
Street drug?	☐ Yes	☐ No	☐ Unsure	If yes, specify:__________
Prescription medication	☐ Yes	☐ No	☐ Unsure	If yes, specify:__________
Nonprescription medication	☐ Yes	☐ No	☐ Unsure	If yes, specify:__________

For office use only:
BMI percentile = ________

Were there stressful events before, during, or right after the pregnancy and birth that were especially difficult for the biological mother (e.g. death of a family member, loss of job, marital conflict)? ☐ Yes ☐ No ☐ Unsure

If yes, please explain:______________________

____

Did any of the following occur during the pregnancy?

Illnesses, infections, fears	❑ Yes	❑ No	❑ Unsure
Bleeding	❑ Yes	❑ No	❑ Unsure
Prolonged labor	❑ Yes	❑ No	❑ Unsure
Induced labor	❑ Yes	❑ No	❑ Unsure
Caesarean section	❑ Yes	❑ No	❑ Unsure
Forceps delivery	❑ Yes	❑ No	❑ Unsure
Breech delivery	❑ Yes	❑ No	❑ Unsure

Did your child have difficulty at birth or shortly thereafter with any of the following?

Premature delivery	❑ Yes	❑ No	❑ Unsure
Postmature delivery	❑ Yes	❑ No	❑ Unsure
Oxygen deficiency	❑ Yes	❑ No	❑ Unsure
Jaundice	❑ Yes	❑ No	❑ Unsure
Breathing problems	❑ Yes	❑ No	❑ Unsure
Feeding problems	❑ Yes	❑ No	❑ Unsure

If your child's birth was premature, how many weeks early was it?____________________

DEVELOPMENTAL HISTORY

What was your child's weight at birth? __________ Lbs, __________ oz. ❑ Unsure

At what age was your child first:

Not sure, but compared to others, seemed to be:

	Years	Months	Later than usual	Usual	Earlier than usual
Sleeping through the night	______	______			
Sitting up	______	______			
Crawling	______	______			
Walking alone	______	______			
Using single words	______	______			
Using sentences	______	______			
Toilet trained	______	______			
Weaned from the bottle or from nursing	______	______			

FAMILY MEDICAL HISTORY

Please check any of the conditions below which apply to a blood relative of your child. Use the appropriate line to indicate whether on the MOTHER's or the FATHER's side and use the name of the relationship relative to the child (e.g. child's aunt, cousin, grandmother, etc.)

		Mother's Side	Father's Side
	Depression		
	Anxiety		
	Other mental illness, inc. schizophrenia		
	Lung disease (emphysema, chronic bronchitis)		
	Alzheimers, Parkinson's Multiple Sclerosis		
	Hepatitis or cirrhosis of the liver		
	Thyroid or glandular disease		
	Stomach problems or ulcers		
	Alcoholism or drug abuse		
	Epilepsy or seizures		
	Kidney or bladder problems		
	Anemia or blood disease		

		Mother's Side	Father's Side
	Nervous system disease		
	Asthma or allergies		
	Mental retardation		
	High blood pressure		
	Heart disease		
	Skin disease		
	Tuberculosis		
	Gallstones		
	Diabetes		
	Colitis		
	Cancer		
	Other		

Do you have concerns about drug and/or alcohol abuse by anyone in your family, whether living in your household or not (not including the child – this will be responded to later)? ☐ Yes ☐ No

If yes, by whom? Please explain:________________________

____

____

LEGAL ISSUES

Are there any legal issues such as those below, that MAY have some effect on how we create a service plan for you and your family?

Is your family currently, or have you in the past, been involved, in any way, with Summit County Children Services or other similar agency? ☐ Yes ☐ No

If yes, please explain:________________________

____

Is your child for who you are seeking help on probation or parole or otherwise under the supervision of the Juvenile Court or Department of Youth Services? ☐ Yes ☐ No

If yes, please explain:________________________

____

Is your child for whom you are seeking help currently the subject of a custody dispute? ☐ Yes ☐ No

If yes, please explain:________________________

____

Does there exist any Court Order that specifically prohibits either the mother or the father of the child from accessing information in medical records? ☐ Yes ☐ No

If yes, please explain:________________________

____

STRESSFUL EVENTS

Please check all those that have occurred over the last twelve months:

☐	Death in the immediate family	☐	Change in children living in the household	☐	Family move
☐	Divorce or separation	☐	Change in school	☐	Other________
☐	Parent job loss	☐	Major illness (child)	☐	Other________
☐	Change in adults living in the household	☐	Major illness of an immediate family member	☐	Other________

Please list any other major stressful events from the child's lifetime:________________________

____

INFORMATION ABOUT YOUR CHILD

Please tell us the problem(s) with which you would like help and any preferences on how services might be provided:

____

____

____

____

____

____

____

____

____

____

____

Please describe your child's strengths and capabilities:

____

____

____

____

____

____

____

Have you or anyone else made prior attempts to get help for these or similar problems you are having? ❑ Yes ❑ No

If yes, please list the agencies and/or individuals you have received help from and the time period they were of service to you:

Agency or individual	Time period (when began & when ended)

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Client Name & Number ____________________

Does your child currently experience:	Never	Occasionally	Frequently
a loss of pleasure in all or almost all activities			
outbreaks of crying, appearing tearful			
think about committing suicide or make attempts			
repeated, unpleasant thoughts or behaviors			

Does your child currently experience physical complaints such as:	Never	Occasionally	Frequently
weight loss or failure to make expected weight gains			
trembling, breaking out in a sweat, racing heart			
difficulty falling asleep or staying asleep			

Does your child:	Never	Occasionally	Frequently
set things on fire to cause serious damage			
deliberately damage other's property			

Has your child:	Never	Occasionally	Frequently
been cruel to other people or animals			
forced anyone engage in sexual activity			
run away overnight			
ever drank alcohol of any kind (beer, wine, liquor)			
ever used street drugs of any kind			
ever witnessed or been exposed to domestic violence			

if so, by ____________________ toward ____________________

(person who was violent) *(victim of the violence)*

	Never	Occasionally	Frequently
ever been a victim of physical or sexual abuse, or of neglect			

if so, please give details____________________

INFORMATION ABOUT FRIENDS

To what extent does your child's choice of friends concern you?

1 2 3 4 5

A great deal — Not at all

To what extent do you approve of your child's activities with his/her friends?

1 2 3 4 5

Not at all — A great deal

How well does your child get along with friends?

1 2 3 4 5

Terribly, he/she seems unable to keep friends at all — Very well, he/she has at least several long-standing friendships

____________________ Person(s) completing questionnaires

____________________ Date

THANK YOU

OFFICE USE ONLY – PLEASE LEAVE BLANK

Physical health and nutrition information reviewed by:
❑ Psychiatrist ❑ Other Physician ❑Nurse

____
Signature Date

Recommendation for referral to physical health services:
❑ Yes ❑ No

If yes, date letter sent to client and by whom:

____
Name

Recommendation for referral for nutritional assessment:
❑ Yes ❑ No

If yes, date letter sent to client and by whom:

____
Name Date