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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_____

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 ❑ American Indian ❑ 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:_____

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Other adults currently living in the same household as minor:

Full Name	Date of Birth	Relationship (to minor)

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

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#: _____

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

Does your child have siblings, half-siblings, step-siblings, that currently live elsewhere? ❑ Yes ❑ No

If yes, please provide the following information:

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

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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_____

Does your child have a good attitude about going to school? ❑ Yes ❑ No, explain _____

_____

_____

Does your child demonstrate behavioral concerns at school? ❑ No ❑ Yes, explain _____

_____

_____

Does your child typically complete their schoolwork? ❑ Yes ❑ No, explain _____

_____

_____

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

MINOR'S MEDICAL HISTORY

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

Physician's Address _____

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

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

Does your child have any food allergies? (list below) ❑ Yes ❑ No

Does your child have other allergies? (list below) ❑ 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:_____

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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? ❑ No ❑ Yes, explain _____

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?

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

☐	Visual problems	☐	Sore throat/ frequent cough	☐	Dental problems	☐	Frequent infections
☐	Hearing loss	☐	Breathing problems	☐	Nausea/vomiting	☐	Soiling/wetting concerns
☐	Appetite problems	☐	Nosebleeds	☐	Menstrual pain	☐	Fainting spells/blackouts
☐	Sleeping problems/fatigue	☐	Headaches	☐	Diarrhea/constipation	☐	High fevers
☐	Pain issues	☐	Other _____	☐	Other _____	☐	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:_____

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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 substances during pregnancy? ❑ No ❑ Yes, explain _____

_____

_____

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:_____

_____

Were there complications during pregnancy or delivery, or after birth? ❑ Yes ❑ No ❑ Unsure

If yes, please explain:_____

_____

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

Did your child reach developmental milestones during a typical range? ❑ Yes ❑ No, explain _____

_____

_____

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		
	Substance Use Issues		

		Mother's Side	Father's Side
	Developmental Delays		
	Asthma or allergies		
	Significant Health Concerns		
	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:_____

_____

_____

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LEGAL ISSUES

The following legal issues MAY have some effect on how we create a service plan for you and your family. Please answer below.

Is your family currently, or have you in the past, been involved, in any way, with Child Protective 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:_____

_____

Has the child for whom you are seeking help currently ever been 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

Has your child experienced any recent (past 12 months) stressful life events, such as a death in the family, divorce, parent job loss, move, etc? ❑ Yes ❑ No

If yes, please explain:_____

_____

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:

_____

_____

_____

Has your child received mental health treatment? ❑ Yes ❑ No

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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)

OTHER

Has your child been cruel to other people or animals? ❑ Yes ❑ No

Has your child used alcohol or other substances? ❑ Yes ❑ No

Has your child witnessed domestic violence ❑ Yes ❑ No

Has your child experienced a traumatic event? ❑ Yes ❑ No

SOCIAL

Do you have concerns about your child's choice of friends? ❑ Yes ❑ No

Do you approve of your child's activities with his/her friends? ❑ Yes ❑ No

Does your child get along well with others? ❑ Yes ❑ No

_____ _____

Person completing questionnaire signature Date

THANK YOU

OFFICE USE ONLY – PLEASE LEAVE BLANK

For office use only:

BMI percentile = _____

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

❑ Review completed, no further action is needed

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

Recommendation for referral for nutritional assessment:
❑ Yes ❑ No

_____
Signature Date

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

_____
Name

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

_____
Name Date