Log #: _____

C&S Clinic Intake & Registration Form – Child / Adolescent (Under 18)

Directions: Please answer the following questions to the best of your knowledge.

These records are confidential. Information will not be released to any party without legal or written consent.

PATIENT INFORMATION

Child's Last Name	First Name	Middle	Child's Social Security #	Date Form Completed:

Child's Street Address	City	State	Zip	OK to Send Letter? ☐ Yes ☐ No	Gender: ☐ Male ☐ Female ☐ Trans

Primary Phone	OK to Call? ☐ Yes ☐ No	Child's Phone	OK to Call? ☐ Yes ☐ No	Current Age:

Birth Date (MM/DD/YYYY)	Child's Status: ☐ Single (without partner) ☐ Married ☐ Single with partner	Who Referred This Child For Services?

Child's Gender (*or preferred term*) ☐ Male ☐ Female ☐ Transgender ☐ _____	Child's Sexual Orientation (*or preferred term*) ☐ Gay ☐ Straight ☐ Bisexual ☐ _____	Child's Preferred Pronouns

CHECK ALL THAT APPLY:

Race / Ethnic Heritage:

☐ American Indian / Alaska Native
Enrolled? ☐ Yes ☐ No

Tribe: _____

☐ Asian American or Asian: _____
☐ Black/African American or African: _____
☐ White/European American: _____
☐ Native Hawaiian / Other Pacific Islander: _____
☐ Hispanic, Chicano/a, or Latino/a: _____
☐ Other: _____

Current School (or Employer, if no school)	Grade	Contact Person (School Social Worker, Teacher)	Highest Education:
			□ Preschool □ Elementary □ Jr. High □ High School □ Vocational □ College

Street Address	City	State	Zip	Phone

Emergency Contact Person	Phone Number	Relationship	Is child currently homeless? ☐ Yes ☐ No

LEGAL GUARDIAN INFORMATION – *WHO HAS LEGAL CUSTODY? ☐PARENT, ☐COUNTY, ☐TRIBE, ☐RELATIVE, ☐OTHER:_____*

(Please note that foster parents are not generally authorized as a legal guardian, unless a court order has been issued stating such.)

Last Name	First Name	Middle	Social Security Number	Gender:

Street Address	City	State	Zip	OK to Send Letter? ☐ Yes ☐ No	Birth Date (MM/DD/YYYY)

Primary Phone	OK to Call? ☐ Yes ☐ No	Other Phone	OK to Call? ☐ Yes ☐ No	If No, How can you be reached?

<u>If you do not have insurance</u>:

The Indian Health Board provides *<u>free Eligibility Assistance</u>* to help you apply. We will gladly schedule you to see our Insurance Navigator to find all your options.

Indian Health Board also has a sliding fee discount program based on income and ability to pay that may reduce the bill you owe. Please ask the registration staff for a Sliding Fee Discount Form.

INSURANCE INFORMATION - PRIMARY

□ Blue Cross/Shield/Plus	□ HealthPartners	□ Medica	□ Medical Assistance (no PMAP/HMO assigned)	
□ Medicare	□ Metropolitan Health Plan	□ Minnesota Care	□ PreferredOne	□ UCare
□ Other: _____		□ Self-Pay / Sliding Fee	□ I would like to apply for insurance	

PMI # (Eight Digits):	Insured Member's ID #:	Policy / Group #:	Co-Pay Amount (if any):	Customer Service Phone #:

INSURANCE INFORMATION – SECONDARY (IF APPLICABLE)

□ Insurance Company	Insured Member's ID #:	Policy / Group #:	Customer Service Phone #:

REFERRAL INFORMATION: *(REASON FOR WANTING SERVICES)*

Check all that apply:

☐ Sadness / Depression	☐ Stress	☐ Grief / Death / Loss	☐ Alcohol Use	☐ Eating Disorder	☐ Foster Care
☐ Bipolar Depression	☐ Trauma	☐ Sexual Abuse/Trauma	☐ Drug Use	☐ Phobia	☐ Adoption
☐ Hopelessness	☐ Anxiety / Worries	☐ Physical Abuse	☐ Huffing	☐ Behavior Problems	☐ Strange Thoughts
☐ Mood Swings	☐ Panic Attacks	☐ Emotional Abuse	☐ FAS / FASD	☐ School Problems	☐ Psychiatric Hospitalization
☐ Anger	☐ Inattention	☐ Neglect	☐ HIV / AIDS / HEP-C	☐ Learning Problems	☐ Sexuality Concerns
☐ School Refusal	☐ Hyperactivity	☐ Witness Domestic Abuse	☐ Other health problems	☐ Legal Problems	☐ Cultural Resources

☐ Other *(Describe)*: _____

_____

TYPE OF SERVICE(S) REQUESTED: *(CHECK ALL THAT MAY APPLY – A THERAPIST WILL DISCUSS OPTIONS WITH YOU)*

Check all that apply:

☐ Individual Therapy	☐ Family Therapy	☐ Group Therapy	☐ Psychological Testing
☐ Drum Group	☐ Rule 25 Assessment	☐ Other: _____	

_____

PLEASE LIST ALL PEOPLE LIVING WITH THE CHILD / ADOLESCENT:

Name	Relationship to child	Sex	Birth Date	Race / Tribe
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

FAMILY / CAREGIVER INFORMATION – *PLEASE COMPLETE ALL APPROPRIATE BLANKS*

Birth Mother's Name	Birth Father's Name	Adoptive Mother's Name	Adoptive Father's Name
Foster Mother's Name	**Foster Father's Name**	**Other Caregiver's Name**	**Other Caregiver's Name**

CHILD'S / ADOLESCENT'S PRIMARY CARE PHYSICIAN(S)

Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

OTHER CURRENT PROVIDER(S) OR PROFESSIONAL(S) – E.G., PSYCHIATRIST, SOCIAL WORKER, ADVOCATE, PROBATION, ETC.

Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

PAST PROVIDER(S) OR PROFESSIONAL(S) – *E.G., PSYCHOLOGIST, PSYCHIATRIST, SOCIAL WORKER, ETC.*		
Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

CHILD'S / ADOLESCENT'S MEDICATIONS: *(LIST MORE ON SEPARATE PAGE IF NECESSARY)*

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

PAST MEDICATIONS / FOR WHAT CONDITION? *(LIST MEDICATIONS FOR DEPRESSION, ADHD, MEDICAL CONDITIONS, ETC.)*

Medication Name	For what condition?	Dosage	Frequency	Dates / Age of Child	Comments / Problems / Concerns

CHILD'S ALLERGIES:

Medication Allergies? ☐ Yes ☐ No Substance or Food Allergies? ☐ Yes ☐ No

If yes, what medication(s) _____ If yes, what: _____

CHILD'S PAIN ISSUES:

Chronic Pain? ☐ No ☐ Yes If yes, where are you treated for this? _____

CHILD'S NUTRITIONAL HEALTH: *(PLEASE DESCRIBE THE STATE OF YOUR CHILD'S NUTRITIONAL HEALTH (E.G., DIET, HEALTHY EATING, ACCESS TO FOOD, ETC.))*

☐ Poor ☐ Fair ☐ Good ☐ Vegetarian ☐ Gluten-sensitive ☐ Other: _____

CHILD'S CULTURAL / SPIRITUAL HISTORY

☐ Yes ☐ No	Are there cultural or spiritual issues to discuss that would be important in counseling?

YOUR LEARNING STYLE (CAREGIVER OF THE CHILD):

I prefer *(check all that apply):*			Please circle your answer to the following:		
	Talking, Asking Questions		Can you read English well?	Yes	No
	Reading		Can you write English well?	Yes	No
	Listening		Can you hear well?	Yes	No
	Pictures, Diagrams		Can you see well?	Yes	No
	Self-Study		Do you have any learning problems?	Yes	No, I have no learning disability

WHAT HAS BEEN SAID TO THIS CHILD ABOUT RECEIVING TREATMENT FROM THE COUNSELING & SUPPORT CLINIC?

OTHER INFORMATION – How urgently would you like the child / adolescent to be seen?

☐	It's an emergency – the child is suicidal or at risk of harming others.
☐	I would like this child to be seen as soon as possible.
☐	My concerns are important, but I am able to wait.
☐	I am willing to wait some additional time to see a specific therapist or type of therapist. Specify:

– Is there any other information related to this referral that you wish to share with us at this time?

I certify that I have answered these questions to the best of my knowledge:

Signature: _____Date: _____

Person Completing this Form: _____Relationship to Patient: _____

CLINICIANS NOTES (CLARIFICATIONS / FOLLOW UP / ETC)

	Reviewed by (Clinician):	Date:

The Remaining Pages Request Background Information Regarding The Child That You Are Referring For Services.

Although it may seem like a lot, the information helps us do a better job and will speed things up. The more complete the information, the better the services we can provide. All information will be held strictly confidential.

A. Biological Mother's History of Chemical Use during Pregnancy

1. Please fill in every square to tell us about the pregnancy. **If the answer is "no" or "none" for any square, then please put a line or slash mark ("/") in that square.**

Check if True: ___ *"I don't know some or all of this information because I am not the birth mother or do not know about the birth mother during her pregnancy."*

	The Six Weeks Before Pregnancy	1st Trimester	2nd Trimester	3rd Trimester
Infections -Colds, flu, etc. -Chlamydia, gonorrhea, etc. -Bladder infection, etc.				
Medications *(Other than vitamins)*				
Accidents / Injuries -Car accidents -Falls, punches, etc.				
Smoking -About how many cigarettes per day…				
Alcohol Use **-What kind?** (Beer, wine, etc.)				
-How often? (Daily, twice a week, every weekend, etc.)				
-How much? (A case, six pack, half a bottle, etc.)				
Drug Use **-What kind?** (Pot, speed, crack, glue, etc.)				
-How much?				
-How often? (Daily, twice a week, every weekend, etc.)				

2. Please list all Alcohol and/or Chemical Dependency Treatment programs that the child's mother attended during or within one year before or after the pregnancy with this child:

Treatment Program Name(s), *if known*	Before, During, or After Pregnancy – Circle One			Completed? – Circle One		
a.	**Before**	**During**	**After**	**Yes**	**No**	**Unknown**
b.	**Before**	**During**	**After**	**Yes**	**No**	**Unknown**
c.	**Before**	**During**	**After**	**Yes**	**No**	**Unknown**
d.	**Before**	**During**	**After**	**Yes**	**No**	**Unknown**

Check if True: ___ *"I don't know some or all of this information, because I am not the birth mother or do not know about the birth mother during this time period."*

B. Other Pregnancy and Delivery Information

Please answer every question that you know or remember.

Check if True: ___ *"I don't know some or all of this information because I am not the birth mother or do not know about the pregnancy or delivery."*

1.	Was the pregnancy with this child planned?	**__ Yes**	**__ No**	**__ Don't Know**
2.	How long was the pregnancy with this child in weeks?	**_____ Weeks**	**APGAR: 1 min ____ 5 min ____**	
3.	Child's weight at birth:	**_____ pounds, _____ ounces**		
4.	Child's length at birth:	**_____ inches**		
5.	How many days did the mom spend in the hospital?	**_____ Days**	How many days did the baby?	**_____ Days**
6.	Which pregnancy for mom (1st, 2nd, 3rd etc.)?	**_____**	Mom's age at child's birth	**_____ years old**
7.	Please describe any complications of labor or delivery (e.g., induced labor, caesarian section, "blue baby," jaundice, etc.):			

C. Child's Developmental History

Please answer every question that you know or remember.

Check if True: ___ *"I don't know some or all of this information because I did not know the child during this time period."*

1.	In the first year of life, was this child…			
	…predictable in eating habits?	**__ Yes**	**__ No**	**__ Don't Know**
	…predictable in sleeping habits?	**__ Yes**	**__ No**	**__ Don't Know**
	…colicky or very fussy?	**__ Yes**	**__ No**	**__ Don't Know**
2.	When was this child able to do the following…			
	…smile?	**_____ months**	…walk?	**_____ months**
	…sit up?	**_____ months**	…first words?	**_____ months**
	…crawl?	**_____ months**	…1st sentence?	**_____ months**
	…potty trained?	**_____ months**	…dry during night	**_____ months**
3.	Who was this child emotionally attached to most?	**__ Mother**	**__ Father**	**__ Someone else: _____**
4.	Please describe any changes in primary caretakers for this child during the first three years of life:			

D. Child's School and Program History (Please answer every question that you know or remember.)

Check if True: ___ *"I don't know some or all of this information because I did not know the child during all of this time period."*

1.	Please list the names of the following programs that your child has attended…		
	…Day care:		When_____
	…Head Start:		When_____
	…Preschool:		When_____
2.	Please describe any concerns this child had in any of these early childhood programs:		
3.	List all schools this child has attended, beginning with the current one and going backward…		
	Current School:	Grades:	City/State:
	School:	Grades:	City/State:
	School:	Grades:	City/State:
	School:	Grades:	City/State:
4.	Please describe any education or behavior concerns this child had at any of these schools:		
5.	Please describe any special services or programs this child receives (e.g., Special Ed, Chapter One, Gifted, Speech, OT, groups, etc.):		

E. Child's Sexual History

Please answer every question that you know.

1.	Has this child sought any sexual information from you or others?	**__ Yes**	**__ No**	**__ Don't Know**
2.	Has this child started developing sexual characteristics?	**__ Yes**	**__ No**	**__ Don't Know**
3.	Please describe any sexual materials or activity this child has been exposed to (e.g., videos, magazines, adult behavior, internet, etc.):			
4.	To your knowledge, has this child ever been sexually abused?	**__ Yes**	**__ No**	**__ Don't Know**
	If yes, please describe any treatment, counseling, etc. that may have occurred (please list approximate dates as well):			
5.	Is this child sexually active?	**__ Yes**	**__ No**	**__ Don't Know**

F. Child's Medical History (Please answer every question that you know or remember.)

Check if True: ___ *"I don't know some or all of this information because I did not know the child during all of this time period."*

1.	Please describe any serious or chronic illnesses this child has had and at what age. Examples include PE tubes, high fever, seizures, asthma, etc.	
	Illness:	Approximate age:
	Illness:	Approximate age:
	Illness:	Approximate age:
2.	Please describe any hospitalizations, head injuries, stitches, surgeries, etc.	
	Problem:	Approximate age:
	Problem:	Approximate age:
	Problem:	Approximate age:
3.	Please describe any current health problems, allergies, or physical disabilities.	
	Problem:	Approximate age:
	Problem:	Approximate age:
	Problem:	Approximate age:

G. Child's Social History and Activities (Please answer every question that you know.)

1.	What time does this child…			
	…go to bed on school nights?		…wake up?	
	…go to bed on weekends?		…wake up?	
2.	Does this child have problems with… (Check ALL that apply):			
	___	Falling asleep, bedtime	___	Sleepwalking
	___	Waking up during the night	___	Bedwetting
	___	Nightmares or night terrors	___	Overeating
	___	Waking up in the morning for school	___	Eating too little
3.	Does this child have a best friend?	**__ Yes**	**__ No**	**__ Don't Know**
	How does this child play or get along with peers? Are friends usually older or younger? Do this child fight with or withdraw from friends when angry with them?			
4.	Do you feel uncomfortable about this child's friends or activities?	**__ Yes**	**__ No**	
	If yes, please share your concerns:			
5.	Has child experimented with or currently uses cigarettes, alcohol, or street drugs (including weed, meth, or prescription drugs)?	**__ Yes**	**__ No**	**__ Not Sure**

	If yes or not sure, please share your concerns:			
6.	Has this child been involved with gangs or gang activity?	**__ Yes**	**__ No**	**__ Not Sure**
	If yes or not sure, please share your concerns:			
7.	Has this child been involved with police or juvenile justice?	**__ Yes**	**__ No**	**__ Not Sure**
	If yes or not sure, please share your concerns:			

H. Child's Family History and Background

Please check each of the following areas that this child or family members have had problems with now or in the past.

Illness or Problem Area	Child	Biological Mother	Mother's Family	Biological Father	Father's Family
Cancer					
Deafness					
Diabetes					
Heart Problems					
Seizures, convulsions					
Depression					
Manic Depression, Bipolar Depression					
Schizophrenia					
Other Psychiatric Disorder					
Psychiatric Hospitalization					
Hyperactivity					
Inattention					
Bedwetting					
Behavior Problems					
Learning Problems					
Mental Retardation					
Alcohol Problems					
Drug Problems					
Domestic Abuse					
Legal Difficulties					
Incarceration					
Foster Care					
Physical Abuse					
Sexual Abuse					
Neglect					
Psychological Abuse					