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Initial Child/Youth Contact Sheet

Today's Date: MM/DD/YY

GENERAL INFORMATION

Referred by: Referral Source Phone #:

Client name on Medi-Cal card: Medi-Cal #: MC # ☐ M ☐ F Age:

Client Name on Medi-Cal Card Date of Issue: Date of Issue

Social Security Number: SSN

Client's Full Birth Name (Last, First, Middle): Last Name First Name Full Middle Name

Responsible Person's Name: Last Name First Name Full Middle Name

Responsible Person's Address (Street, City, State, Zip) Relationship to Client:

Legal Consent? ☐ Yes ☐ N

Communications: Okay to Leave Message?

		Okay to Leave Message?
Home Phone:	Home	☐ Y ☐ N
Work Phone:	Work	☐ Y ☐ N
Cell Phone:	Cell	☐ Y ☐ N
eMail:	eMail Address	☐ Y ☐ N
Other:	Other	☐ Y ☐ N

Does the client live at the above address? ☐ Y ☐ N If not, what is the client's address?

Client's Street Address: Street Address City/State/Zip: City/State/Zip

School District: School District Grade: Preferred Language of parent/guardian:

Client's Ethnicity:

Physical Disability:

Where was client born? City/County/State/Country

Client's Mother's First Name:

List all persons (including the client) and their age living in the home and their relationship to the client below:

People in Household	Date of Birth MM/DD/YY	Relationship to Client
Name , age		
Name , age		
Name , age		
Name , age		
Name , age		
Name , age		
Name , age		
Name , age		

DEVELOPMENTAL HISTORY

PREGNANCY and BIRTH

Mother's health during pregnancy? ☐ Good ☐ Fair ☐ Poor

Full Term? ☐ Yes ☐ No

Problems with labor and delivery? (Please explain.)

Were there any unusual circumstances or difficulties during pregnancy or the first few months of the child's life?

TEMPERAMENT as an INFANT

When your child was an infant was he/she: (Check one item in each row.)

☐ Very easy	☐ Easy	☐ Average	☐ Difficult	☐ Very Difficult
☐ Very insistent	☐ Pretty insistent	☐ Average	☐ Not very insistent	☐ Not at all insistent
☐ Very active	☐ Active	☐ Average	☐ Less Active	☐ Not active

☐ Always crying ☐ Cried frequently ☐ Average ☐ Cried Less ☐ Never Cried

How did your child react to being held or comforted? ☐ Enjoyed ☐ Indifferent ☐ Resisted

Did your child have favorite stuffed animals or objects that helped self-sooth when distressed? ☐ Yes ☐ No

DEVELOPMENTAL MILESTONES

At what age die your child: Sit up? ____________ Crawl? ____________ Walk? ____________

Speak a single word other than 'Mama' or 'Dada'? ____________

String 2 or more words together? ____________

Any concerns with speech or language development?

Have bladder control? ☐ No ☐ Yes, at what age? ____________

Have bowel control? ☐ No ☐ Yes, at what age? ____________

Is there anything about your child's development that continues to concern you?

MEDICAL HISTORY

How would you describe your child's health? ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Does your child have a chronic medical condition? ☐ No ☐ Yes, describe:

Has your child had any serious illnesses? ☐ No ☐ Yes, describe:

Does your child have any allergies? ☐ No ☐ Yes, describe:

Has your child had any serious accidents? ☐ No ☐ Yes, describe and give age:

Has your child ever been hospitalized? ☐ No ☐ Yes, describe and give age:

MENTAL HEALTH TREATMENT HISTORY

	Type of Treatment	Dates	Was it helpful?
1			☐ Yes ☐ No
2			☐ Yes ☐ No
3			☐ Yes ☐ No
4			☐ Yes ☐ No

Current Psychiatric Medications

	Name of Medication	Dose	Frequency
1			
2			
3			
4			

SCHOOL & SCHOOL FUNCTIONING

Has your child been held back a grade or repeated a grade? ☐ No

☐ Yes, which grade?

How did your child function in school? (Check one for each category/row.)

	ACADEMIC	BEHAVIORAL	Number of Schools
Pre-School	☐ Poor ☐ Average ☐ Good	☐ Poor ☐ Average ☐ Good	
Kindergarten	☐ Poor ☐ Average ☐ Good	☐ Poor ☐ Average ☐ Good	
Grades 1 – 3	☐ Poor ☐ Average ☐ Good	☐ Poor ☐ Average ☐ Good	
Grades 4 – 6	☐ Poor ☐ Average ☐ Good	☐ Poor ☐ Average ☐ Good	
Grades 7 – 9	☐ Poor ☐ Average ☐ Good	☐ Poor ☐ Average ☐ Good	
Grades 10 – 12	☐ Poor ☐ Average ☐ Good	☐ Poor ☐ Average ☐ Good	

Has your child received any of the following *Special Education* programs?

Resource Specialist Class	From:	To:
Speech and Language Therapy	From:	To:
Special Day Class	From:	To:
One-to-One Aide	From:	To:
Behavioral Assessment and Plan	From:	To:

Other:

	This Year	Previous School Year
How many times was your child:		
Kept after school:		
Suspended:		
Expelled:		

Social Functioning

Does your child have trouble making friends?
☐ No
☐ Yes, when did you become aware of this difficulty?

Does your child have a best/close friend? ☐ No ☐ Yes

How does your child get along with brothers/sisters?

How does your child get along with adults?

Does your child participate in any group activity? ☐ No ☐ Yes, which?

Community Functioning

Has your child had any difficulties with the law, been arrested or been detained at Juvenile Hall?	☐ No ☐ Yes, please explain:
Has your child been removed from home or received services from Child Protective Services?	☐ No ☐ Yes, please explain:
Has your child used drugs or alcohol?	☐ No ☐ Yes—Please describe the substances used, frequency of use, and any circumstances resulting from the substance use.

OTHER CONCERNS

SLEEP PROBLEMS On average, my child/teenager sleeps ____ hours per night.

Trouble falling asleep? ☐ No ☐ Yes Trouble staying asleep? ☐ No ☐ Yes
Wakes up too early? ☐ No ☐ Yes Has nightmares? ☐ No ☐ Yes

TROUBLE WITH EATING ☐ No ☐ Yes
Has your child gained or lost weight in the past year? ☐ No ☐ Yes If yes, how much? pounds ☐ Gain ☐ Loss
Uncontrollable urge to eat? ☐ No ☐ Yes
Vomit after eating? ☐ No ☐ Yes

Refusal to eat?	☐ No ☐ Yes

IDENTIFICATION OF ISSUES, GOALS, INTERVENTIONS & TREATMENT BARRIERS

	Caregiver Words	**Child/Youth Words**
Reason for seeking therapy?		
Goals of therapy/what changes are desired?		
Priorities for intervention:		
Any treatment barriers (i.e. scheduling, transportation, special needs, and etc.)?		

Form Completed By: Relationship to Client: