| # CHILDREN’S ADVANTAGE NEW CLIENT INFORMATION FORM | Client #:<br>Therapist: |
|---|---|

Client Name:________________________________________DOB:____________________

Address (Street, City, Zip):__________________________________________________

Primary Phone #: __________________________SSN: ______________________Gender: ______________

**IF CHILD IS UNDER THE AGE OF 18 - VERIFICATION OF LEGAL RIGHT TO CONSENT (GUARDIANSHIP)**

Legal Guardian Name(s)/Relation:________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Relationship to child (***MUST provide documentation**)**

☐ Biological/Adoptive Mother ☐ Biological/Adoptive Father ☐ Grandmother* ☐ Grandfather* ☐ Aunt*

☐ Uncle*☐ SCCS* ☐ Other (specify i.e. POA, sibling, etc)*

______________________________________

Has the child ever previously been in legal custody of any Children Services Board? ☐ yes ☐ no

If YES, when and where? ***MUST provide documentation*** ________________________________

Name of biological/adoptive mother:____________________________Phone:_____________________

Name of biological/adoptive father:_____________________________Phone:_____________________

Were parents married at the time of the child’s birth? ☐ yes ☐ no

If YES, are parents still married? ☐ yes ☐ no

If NO, when and where were parents divorced? ______________________________
***MUST provide documentation*** *(indicate if parent is deceased)*

| GENERAL CONSENT FOR SERVICES | |
|---|---|
| ☐ **I consent for Children’s Advantage to conduct an assessment and to provide mutually agreed upon, medically necessary services.**<br><br>**I have received an explanation about the risks and the benefits of any proposed services, alternative services and of having no services at all.**<br><br>**I have received a copy of the Clients Rights Summary, HIPAA Privacy Policies and Children’s Advantage No-Restraint Policy and have had the opportunity to review them.** | |
| Client signature (required if 14 or older): | Date: |
| Signature of Legal Guardian (if client is under the age of 18): | Date: |

Clients Name: ________________________________ Today's Date:____________________

## CLIENT DEMOGRAPHICS

**RACE** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Middle Eastern ☐ Multiracial ☐ Natie Hawaaiian/Other Pacific Islander ☐ Other ☐ White ☐ Decline

**ETHNICITY** ☐ Cuban ☐ Hispanic/Latino ☐ Mexican ☐ Native American ☐ Nonhispanic/Latino ☐ Puerto Rican ☐ Decline

**MARITAL STATUS** ☐ Single ☐ Married ☐ Mexican ☐ Life Partner/Significant Other ☐ Separated ☐ Divorced ☐ Widowed

**RELIGIOUS AFFILIATION** ☐ Catholic ☐ Islam ☐ Jewish ☐ Protestant ☐ Other:____________ ☐ Decline

**TOBACCO USE** ☐ Never Smoked ☐ Current smoker ☐ Former smoker ☐ Unknown if ever smoked

**PRIMARY LANGUAGE** ☐ English ☐ Other:________________ ☐ Additional Language: ______________

**EDUCATION (Check highest level completed)** ☐ Elementary ☐ Middle School ☐ High School ☐ College ☐ Trade Training

**EMPLOYMENT STATUS** ☐ Full time ☐ Part time ☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐ Unemployed

## ADULTS AND CHILDREN LIVING IN OR OUTSIDE THE HOME (INCLUDE MOTHER AND/OR FATHER)

1. ________________________________Relationship:______________________ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A

2. ________________________________Relationship:______________________ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A

3. ________________________________Relationship:______________________ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A

4. ________________________________Relationship:______________________ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A

5. ________________________________Relationship:______________________ Quality of Relationship
   Name Age ☐ In Home ☐ Outside of Home ☐ Good ☐ Fair ☐ Poor ☐ N/A

**EMERGENCY CONTACT:** Name:________________________________ Relationship to Client::_______________________
Phone:__________________________ ☐ Cell ☐ Home

**CURRENT SYMPTOMS: Please check any of the following which have been a problem or concern in the past 2-4 months**

**Behavioral**
- ☐ Oppositional/Argumentative
- ☐ Destruction Of Property
- ☐ Lying/Stealing
- ☐ Aggressive Towards Others
- ☐ Angry/ Hurting Others
- ☐ Thoughts Of Harming Self/Others
- ☐ Hyperactive/Impulsive
- ☐ Memory Problems
- ☐ Odd / Troubling Thoughts
- ☐ Hearing Voices Seeing Things
- ☐ Other

**Emotional**
- ☐ Loss Of Pleasure/Interests
- ☐ Sleeping Problems
- ☐ Nightmares
- ☐ Unusual Tiredness
- ☐ Appetite/Eating Problems
- ☐ Sadness
- ☐ Tearfulness
- ☐ Anxiety/Nervousness
- ☐ Panicky/Panic Attacks
- ☐ Withdrawn/Isolated
- ☐ Loneliness
- ☐ Sexual Concerns
- ☐ Alcohol/Drug Use
- ☐ Other

**Stressors**
- ☐ Work/School Conflicts
- ☐ Domestic Violence
- ☐ Divorce/Separation
- ☐ Grief/Loss
- ☐ Peer Relations
- ☐ Poor Self-Esteem/Image
- ☐ Major Illness Of Client/Family
- ☐ Legal Problems/Probation
- ☐ Restraining/Protection Order
- ☐ Csb/Court-Ordered Counseling
- ☐ Experienced/Witnessed Trauma
- ☐ Absent Incarcerated Parent
- ☐ Dependent Family Member
- ☐ Change In Home/School Setting
- ☐ Other

**Physical**
- ☐ Headaches
- ☐ Vision/Hearing
- ☐ Swallowing
- ☐ Dental
- ☐ Chest Pain/Breathing
- ☐ Nausea/Constipation
- ☐ Diarrhea/Soiling
- ☐ Abdominal Pain
- ☐ Back Pain
- ☐ Genital Pain/Sores
- ☐ Frequent Infections
- ☐ Coordination/Numbness
- ☐ Fainting Spells

**CLIENT MEDICAL/BIRTH INFORMATION**

Primary Care Physician: ________________________________________ Phone: ______________________________

Date Of Last Physical Exam: _______ Allergies ☐ No ☐ Yes ☐ Explain:

_____________________________________

Current Medications _______________________________ Current Medications ______________________________

*Name Date Reason* *Name Date Reason*

Past Medications _________________________________ Past Medications _________________________________

*Name Date Reason* *Name Date Reason*

Does the client have any physical disabilities? ☐ no ☐ yes ☐ explain:

_____________________________________

Does the client have any developmental disabilities? ☐ no ☐ yes ☐ explain:

_______________________________

Does the client have a history of head injury? ☐ no ☐ yes ☐ explain:

______________________________________

Does the client have a history of alcohol and drug abuse or use? ☐ no ☐ yes ☐ explain:

_____________________

Is there a family history of alcohol / drug abuse abuse? ☐ no ☐ yes ☐ explain:

_____________________________

Is there a blood relative history of major disease or illness? ☐ no ☐ yes ☐ explain:

__________________________

Is there a family history of suicide? ☐ no ☐ yes ☐ explain:

________________________________________________

Is client a victim of sexual or physical abuse? ☐ no ☐ yes ☐ explain:

_______________________________________

**IF CLIENT IS UNDER AGE 18 PLEASE ANSWER THE FOLLOWING QUESTIONS:**

Significant problems with pregnancy or delivery of your child? ☐ no ☐ yes ☐ explain:

_______________________

Did the biological mother use drugs or alcohol during pregnancy? ☐ no ☐ yes ☐ explain:

___________________

Has your child ever been pregnant? ☐ no ☐ yes

Do you have concerns about your child being sexually active? ☐ no ☐ yes

Child development milestones were; ☐ early ☐ on time ☐ delayed

How many times has your child moved for residents from birth to present?________________________________

Clients Name: ______________________________________ Today's Date:___________________________

**DESCRIBE CLIENT INVOLVEMENT**
In The Home: ________________________________________________________________________
Community Supports (Church, Aa, Mentoring Programs): ______________________________________________
Peer Relationships :___________________________________________________________________
Hobbies/Interests/Recreational Activities :______________________________________________________
Work If Applicable: __________________________________________________________________

**INVOLVEMENT IN OTHER AGENCIES**
Please list any other agencies currently involved with you or your family
Agency/Person____________________________________________ Date of Involvment_________________________

**SUMMARY OF NEEDS** Please tell us your main reasons for seeking counseling
______________________________________________________________________________________

**SOURCE OF REFERRAL** ☐ School Staff ☐ Family Friend ☐ Court ☐ County Children Services Board ☐ Self
☐ Akron Children's Hospital ☐ Family Physician ☐ Internet ☐ Community Event ☐ Other