

LAPEER COUNTY COMMUNITY MENTAL HEALTH

CHILD/ADOLESCENT PERSONAL INFORMATION UPDATE FORM

Child's Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip _____

Responsible Party Information:

1. (Circle one) Parent/Guardian/Foster Parent

Name _____ Phone _____

(same) Address _____ City _____ State _____ Zip _____

Education _____ Occupation _____

2. (Circle one) Parent/Guardian/Foster Parent

Name _____ Phone _____

(same) Address _____ City _____ State _____ Zip _____

Education _____ Occupation _____

Parent Information:

Do Parents live together? Yes No

Married Never Married Widowed/Deceased – If so, which parent has passed: _____

Divorce Separated If so, date of divorce/separation _____

If there is a custody agreement in place? Yes No

Are either parent's rights terminated? Yes No If so, which parent: _____

Legal Information:

Is your child facing any charges or on probation at this time? Yes No

Charges: _____ When? _____

Tether/Restrictions: _____

Does child have a primary care physician (PCP)? Yes No Name of PCP: _____

Has your child had psychiatric hospitalization since they have been in services with us? Yes No

If so, when? _____

Name of Hospital: _____

Presenting Problem/Reason for Returning to Services:

Concerns you may have about your child at this time:

Parent Signature: _____

Printed Name: _____

Date _____