Case #:_____

LAPEER COUNTY COMMUNITY MENTAL HEALTH

CHILD/ADOLESCENT PERSONAL INFORMATION 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 yes, date of divorce/separation _____

Is there is a custody agreement in place? ☐ Yes ☐ No

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

Family Information:

Step Parent 1: Name_____ Phone_____

☐ (Same) Address_____ City_____State_____Zip_____

Education_____Occupation_____

Step Parent 2: Name_____ Phone_____

☐ (Same) Address_____ City_____State____Zip_____

Education_____Occupation_____

Siblings:

Half or Full Sibling?

Is this child from a current or previous relationship/marriage?

Name_____Age_____ Half ☐ Full ☐ Current☐ Previous ☐ Parent_____
Name_____Age_____ Half ☐ Full ☐ Current☐ Previous ☐ Parent_____
Name_____Age_____ Half ☐ Full ☐ Current☐ Previous ☐ Parent_____
Name_____Age_____ Half ☐ Full ☐ Current☐ Previous ☐ Parent_____
Name_____Age_____ Half ☐ Full ☐ Current ☐ Previous ☐ Parent_____
Name_____Age_____ Half ☐ Full ☐ Current ☐ Previous ☐ Parent_____

Pregnancy: Any use of alcohol or drugs during pregnancy?_____

Was pregnancy typical? Yes ☐ No ☐ If no, please explain: _____

Was the delivery typical? Yes☐ No☐ If no, please explain: _____

Length of Labor: _____Were there any complications with pregnancy or birth? _____

_____

Was child healthy as infant? (If no please give brief description) _____

_____

Feeding Methods**:** ☐ Bottle ☐ Breast Fed ☐ Both Any Feeding problems? Yes ☐No ☐_____

Sleep Problems? Yes☐ No☐_____

Development: What age did they begin walking?_____ Toilet trained?_____
Talking?_____ Has your child ever received speech therapy? ☐ Yes ☐ No If yes, ☐ Currently ☐ Past

Other information you think is important about your child's development?

_____

_____

Has your child ever lived away from home because of emotional problems or family problems? ☐ Yes ☐ No

If yes, please explain: _____

School Data: Current Grade: _____

Elementary School: _____Area of concern? _____

Middle School:_____Area of concern? _____

High School:_____Area of concern?_____

IEP? ☐Yes ☐ No If yes, Criteria: ☐Learning Disability ☐EI ☐ OHI ☐CI ☐ I'm not sure

504 Plan? ☐Yes ☐ No If yes, Reason: _____

Special Education services? Yes☐ No ☐ If yes, please provide any details: _____

_____

How does your child get along with others children at school/home?_____

_____

How does your child respond to teachers or other authority figures in the school?_____

Legal Information:

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

Charges:_____ When?_____

Tether/Restrictions:_____

Health History:

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

Describe briefly current health:

_____

_____

Serious Childhood Illnesses/dates of illnesses: _____

_____

Medical hospitalization: Yes ☐ No ☐ Hospital:_____Length of stay:_____

Current Treatment for Serious Illness:_____

Please list all medications child is currently prescribed: _____

_____

Please list any allergies to medications: _____

Has your child ever had a Psych Hospitalization? Yes☐ No☐ When? _____

Please give a brief description _____

_____

Has your child had a therapist in the past or current? Yes ☐ No ☐ If yes, ☐ Currently ☐ Past

Therapist Name:_____ Agency_____

Reason for past therapy services: _____

Concerns you have for your child at this time: _____

_____

Parent Signature: _____ Print Name_____

Date_____