

722 15<sup>th</sup> Street NW, PO Box 640 • Bemidji, MN 56619-0640  
Headwaters ACT Team: 408 Beltrami Ave NW, #2  
109 S. Grove Ave. Ste. 1 • Park Rapids, MN 56470

(218) 751-3280 office, (218) 751-3298 fax  
(218) 444-4429 office, (218) 444-5491 fax  
(218) 732-7266 office, (218) 237-8276 fax

Client # \_\_\_\_\_

### Child Service Application

Name of Child: \_\_\_\_\_ Date: \_\_\_\_\_

Child's former name if applicable: \_\_\_\_\_ Sex:  Male  Female

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Name of person completing form: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Who has current legal guardianship of child? (if different than parent): \_\_\_\_\_

Present address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County of residence \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

(Completion of this section is optional) Child's Race:  White  Black  Hispanic  Asian/Pacific  Multi-racial  
 Native American (Enrolled Tribal Member  Yes  No, where \_\_\_\_\_)  Other \_\_\_\_\_

Who referred this child to Sanford Health Behavioral Health Center? \_\_\_\_\_

#### PRESENT PLACEMENT INFORMATION

Child Currently Lives:

- At home with family  
 At a relative's home (name and relationship of custodial adults in this home): \_\_\_\_\_

- In a foster home (name of foster parents) \_\_\_\_\_  
 At a group home or residential facility (name of facility) \_\_\_\_\_  
 Other (please explain) \_\_\_\_\_

Length of time child has been at current placement?: \_\_\_\_\_

#### FAMILY HISTORY

Biological Mother's name: \_\_\_\_\_ Age: \_\_\_\_\_ Lives with child?  Yes  No  
Has the mother or any of the mother's relatives experienced problems similar to those currently experienced by the child?  
 Yes  No. If yes, please Explain: \_\_\_\_\_

Biological Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Lives with child?  Yes  No  
Has the father or any of the father's relatives experienced problems similar to those currently experienced by the child?  
 Yes  No. If yes, please Explain: \_\_\_\_\_

#### MARITAL

Are the biological parents of the child  Married  Separated  Divorced  Living together  
 Never were together  Widowed  Other \_\_\_\_\_

Are the biological parents now remarried or living with a significant other?  Yes  No  
Please describe any abuse, chemical dependency or legal difficulties in the child's immediate relatives: \_\_\_\_\_

Other people residing in the same household with child:

Name	Age	Occupation	Relationship to Child

**EARLY CHILDHOOD DEVELOPMENTAL HISTORY**

Was the pregnancy: a) planned?  Yes  No  
b) welcomed?  Yes  No  
c) stressful?  Yes  No

At any time during the pregnancy did the mother use:

a) prescribed medications  Yes  No If yes, how much? \_\_\_\_\_  
b) recreational drugs  Yes  No If yes, how much? \_\_\_\_\_  
c) alcohol  Yes  No If yes, how much? \_\_\_\_\_  
d) tobacco  Yes  No If yes, how much? \_\_\_\_\_

Were there any medical concerns or other issues during this pregnancy regarding mother and/or baby?  
\_\_\_\_\_

At the time of birth did the baby have?

trouble breathing  Yellow jaundice  blood transfusion  
 resuscitation  jitteriness  physical injuries  
 twin  seizures/fits  trouble sucking  
 birth defects  cord around neck  intensive care  
 fevers or low temperature

Is your child adopted? \_\_\_\_\_ Does child know? \_\_\_\_\_ If not, do you intend to tell the child? \_\_\_\_\_  
At what age was the child placed in your home? \_\_\_\_\_ At what age when adopted? \_\_\_\_\_

Do you have any concerns about your child's motor or muscle development:  Yes  No  
If so, please describe...  
\_\_\_\_\_

Do you have any concerns regarding your child's language development:  Yes  No  
If so, please describe...  
\_\_\_\_\_

**SCHOOL/WORK**

Level of Education: \_\_\_\_\_ Grade: \_\_\_\_\_ Current School: \_\_\_\_\_  
Class Placement:  Mainstream  Special Class (where) \_\_\_\_\_

Teacher or Advisor's name:

IEP in place?  Yes  No

Does the child have any learning disabilities?  Yes  No

If yes, please describe: \_\_\_\_\_

Please list all the schools the child has attended:

Name of School	Address of School	Grade(s) Attended

**MEDICAL**

Who is your child's medical doctor? \_\_\_\_\_

When was your child's last physical examination? \_\_\_\_\_ Results: \_\_\_\_\_

Are there any medical problems we should be aware of and/or that may be impacting your child's mental health?

Yes  No If yes, please explain: \_\_\_\_\_

Has your child been to the Emergency Room to visit in the last year?  Yes  No

If yes, what condition(s)? \_\_\_\_\_

Has there been any history of head trauma, seizures, or loss of consciousness?  Yes  No

If yes, please explain: \_\_\_\_\_

Has your child had past suicide attempts/thoughts? *(Please describe date and method.)*

How: \_\_\_\_\_

When: \_\_\_\_\_

Is your child allergic to or ever had an adverse reaction to any medications?  Yes  No

If yes, please explain: \_\_\_\_\_

Does your child have any other allergies?  Yes  No

For example: foods, airborne \_\_\_\_\_

Is your child pregnant?  Yes  No

Has there been mental health services involved with this child before?  Yes  No

If yes explain: \_\_\_\_\_