SANFORD
HEALTH
Behavioral Health

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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) Atttended

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:______________________________