UMMHC
UPPER MISSISSIPPI
Mental Health Center, Inc.
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(218) 751-3280 office, (218) 751-3298 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 UMMHC?_____

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