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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 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