EMU Psychology Clinic
Child Client Application

Today / Month / Day

Demographic Information

Please fill out the following section for the child client:

Full Name

Address

Gender (please select one):

- [ ] Male
- [ ] Female
- [ ] Transgender
- [ ] Don't know/Unsure/Prefer Not to Answer
- [ ] Other (please specify): 

Race or Ethnicity (mark all that apply):

- [ ] White
- [ ] Black/African-American
- [ ] Hispanic/Latino/Chicano
- [ ] Arab/Middle-Eastern
- [ ] Native American/American Indian/Alaska Native
- [ ] Native Hawaiian/Pacific Islander
- [ ] Don't know/Unsure/Prefer Not to Answer
- [ ] Other (please specify): 

Religious Affiliation (please select one):

- [ ] Christian: Protestant
- [ ] Christian: Catholic
- [ ] Christian: Nondenominational
- [ ] Jewish
- [ ] Muslim
- [ ] None
- [ ] Hindu
- [ ] Buddhist
- [ ] Spiritual/Personal Beliefs
- [ ] Atheist
- [ ] Agnostic
- [ ] Don't know/Unsure/Prefer Not to Answer
- [ ] Other (please specify): 

Sexual Orientation (please select one):

- [ ] Straight/Heterosexual
- [ ] Gay/Lesbian/Homosexual
- [ ] Bisexual
- [ ] Questioning
- [ ] Asexual
- [ ] Don't know/Unsure/Prefer Not to Answer
- [ ] Child has not yet expressed a sexual orientation
- [ ] Other (please specify): 

What is the current annual income of the household in which the child resides (please select one)?

- $150,000 or greater
- $100,000 to $149,999
- $75,000 to $99,999
- $50,000 to $74,999
- $25,000 to $49,999
- $10,000 to $24,999
- Less than $10,000
- Don't Know/Unsure/Prefer Not to Answer

What is the current economic status of the household in which the child resides (please select one)?

- Plenty of "luxuries"
- Plenty of "extras"
- Solidly middle-class
- Barely enough to get by
- Very poor, not enough to get by
- Don't Know/Unsure/Prefer Not to Answer

Does the child—or does a member of the child’s household—receive any of the following kinds of government benefits or assistance (mark all that apply)?

- Food assistance/Food stamps
- Social Security Disability/SSI
- Cash assistance/"Welfare" benefits
- VA Disability Compensation
- HUD/Public housing
- Unemployment benefits
- Child care assistance
- Any other kind of benefit or assistance
- Medicaid
- None of the Above
- Free or Reduced Price School Meals
- Don't Know/Unsure/Prefer Not to Answer

### Parent or Guardian Information

Following are sections which ask about basic information for up to two parents or guardians for the child. Use as many sections as necessary to provide information about who cares for the child. The first section—Parent or Guardian #1—should be used to describe yourself—the person who is completing this document. Use the second section to describe a second biological or other parent.

**Parent or Guardian #1 (this section is used to describe yourself):**

Parental status (please select one):

- Biological Parent
- Step-Parent
- Adoptive Parent
- Legal Guardian
- Other (please specify):

Parental role (please select one):

- Child lives with this parent all or most of the time
- Partial custody (child lives or stays with this parent regularly, but less than half the time)
- Partial custody (child sees this parent a few times a year, on holidays, etc.)
- Occasional, rare contact with child
- No involvement in child’s life
- Other (please specify):

Full Name: ___________________________ Birth Month Day Year:

Address (can write “Same as Child” if so): ___________________________ City, State, ZIP Code: ___________________________
Phone Number (Cell) ____________________________________________

___ □ Yes  □ No __________________________________________________________________

Special Calling Instructions? __________________________________________________________________

Phone Number (Home) ____________________________________________

___ □ Yes  □ No __________________________________________________________________

Special Calling Instructions? __________________________________________________________________

Phone Number (Work) ____________________________________________

___ □ Yes  □ No __________________________________________________________________

Special Calling Instructions? __________________________________________________________________

Gender (please select one):

□ Male □ Transgender

□ Female □ Don’t know/Unsure/Prefer Not to Answer

□ Other (please specify):

Race or Ethnicity (mark all that apply):

□ White □ Asian

□ Black/African-American □ Native American/American Indian/Alaska Native

□ Hispanic/Latino/Chicano □ Native Hawaiian/Pacific Islander

□ Arab/Middle-Eastern □ Don’t Know/Unsure/Prefer Not to Answer

□ Other (please specify):

Religious Affiliation (please select one):

□ Christian: Protestant □ Hindu

□ Christian: Catholic □ Buddhist

□ Christian: Nondenominational □ Spiritual/Personal Beliefs

□ Jewish □ Atheist

□ Muslim □ Agnostic

□ None □ Don’t Know/Unsure/Prefer Not to Answer

□ Other (please specify):

Employment Status (please select one):

□ Employed, Full-Time □ Occasional, Non-Regular Worker/Laborer

□ Employed, Part-Time □ Disabled

□ Self-Employed □ Retired

□ Unemployed, Looking for Work □ Stay-at-Home Parent or Other Caretaker

□ Unemployed, Not Looking □ Don’t Know/Unsure/Prefer Not to Answer

□ Other (please specify):

If the parent or guardian is currently employed, please describe the main place of employment or other work, and his or her title, or what kind of work is done there:

______________________________________________________________________________
Please select the parent or guardian's highest completed level of education (please select one):

- High school diploma
- Associate’s Degree
- GED
- Bachelor's Degree
- Trade degree/Certificate
- Graduate Degree
- Don't Know/Unsure/Prefer Not to Answer

Current Marital/Relationship Status (please select one):

- Single (you can skip the next question)
- In any kind of relationship (e.g., dating, married, etc.)
- Don't Know/Prefer Not to Answer

If the parent or guardian is currently in a relationship of any kind, please describe the relationship situation (please select one):

- In a “Dating” Relationship
- In a “Long-Term” Relationship
- Engaged
- Married
- Married but Separated
- Don't Know/Unsure/Prefer Not to Answer

Past Marriages (mark all that apply):

- Divorced (Please specify number of times)
- Widowed (Please specify number of times)

Please use the next section to describe the other primary parent or guardian for the child. If biological parents are divorced, this can be used to describe the other biological parent; or, it can be used to describe a step-parent, etc.

**Parent or guardian #2:**

Parental status (please select one):

- Biological Parent
- Step-Parent
- Adoptive Parent
- Legal Guardian
- Other (please specify):

Parental role (please select one):

- Child lives with this parent all or most of the time
- Partial custody (child lives or stays with this parent regularly, but less than half the time)
- Partial custody (child sees this parent a few times a year, on holidays, etc.)
- Occasional, rare contact with child
- No involvement in child’s life
- Other (please specify):

---

Full Name

Birth Month Day Year

Address (can write "Same as Child" if so)

City, State, ZIP Code
Phone Number (Cell) ___________________________ Special Calling Instructions? ____________
☐ Yes  ☐ No
☐ OK to leave msg?

Phone Number (Home) ___________________________ Special Calling Instructions? ____________
☐ Yes  ☐ No
☐ OK to leave msg?

Phone Number (Work) ___________________________ Special Calling Instructions? ____________
☐ Yes  ☐ No
☐ OK to leave msg?

Gender (please select one):
☐ Male  ☐ Transgender
☐ Female  ☐ Don’t know/Unsure/Prefer Not to Answer
☐ Other (please specify):

Race or Ethnicity (mark all that apply):
☐ White  ☐ Asian
☐ Black/African-American  ☐ Native American/American Indian/Alaska Native
☐ Hispanic/Latino/Chicano  ☐ Native Hawaiian/Pacific Islander
☐ Arab/Middle-Eastern  ☐ Don’t Know/Unsure/Prefer Not to Answer
☐ Other (please specify):

Religious Affiliation (please select one):
☐ Christian: Protestant  ☐ Hindu
☐ Christian: Catholic  ☐ Buddhist
☐ Christian: Nondenominational  ☐ Spiritual/Personal Beliefs
☐ Jewish  ☐ Atheist
☐ Muslim  ☐ Agnostic
☐ None  ☐ Don’t Know/Unsure/Prefer Not to Answer
☐ Other (please specify):

Employment Status (please select one):
☐ Employed, Full-Time  ☐ Occasional, Non-Regular Worker/Laborer
☐ Employed, Part-Time  ☐ Disabled
☐ Self-Employed  ☐ Retired
☐ Unemployed, Looking for Work  ☐ Stay-at-Home Parent or Other Caretaker
☐ Unemployed, Not Looking  ☐ Don’t Know/Unsure/Prefer Not to Answer
☐ Other (please specify):

If the parent or guardian is currently employed, please describe the main place of employment or other work, and his or her title, or what kind of work is done there:

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________

__________________________________________
Please select the parent or guardian’s highest completed level of education (please select one):

- □ High school diploma
- □ Associate’s Degree
- □ GED
- □ Bachelor’s Degree
- □ Trade degree/Certificate
- □ Graduate Degree
- □ Don’t Know/Unsure/Prefer Not to Answer

Current Marital/Relationship Status (please select one):

- □ Single (you can skip the next question)
- □ In any kind of relationship (e.g., dating, married, etc.)
- □ Don’t Know/Prefer Not to Answer

If the parent or guardian is currently in a relationship of any kind, please describe the relationship situation (please select one):

- □ In a “Dating” Relationship
- □ In a “Long-Term” Relationship
- □ Engaged
- □ Married
- □ Married but Separated
- □ Don’t Know/Unsure/Prefer Not to Answer

Past Marriages (mark all that apply):

- □ Divorced (Please specify number of times) ___________
- □ Widowed (Please specify number of times) ___________

![Reason for Seeking Services](image)

How did you learn about the EMU Psychology Clinic?

____________________________________________________________________________________

Please briefly describe the kinds of problems the child is experiencing that have led you to seek services.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

What are your goals for services—what do you want to achieve, find out, make better, or be able to do?

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
When did the child’s main problem start? Please specify a month and year—if you’re not sure or don’t remember exactly, try to give your best estimate.

_________________________/________________________
Month Year

Did the main problem start after some specific event that happened to the child, or did it seem to come along on its own? Did it come on gradually or all at once? When or how did you first notice it? Please describe.

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Has anything in particular happened recently to cause you to seek help for the child right now?

________________________________________________________________________________________
________________________________________________________________________________________

Pregnancy and Labor Health History

The following questions refer only to the child client in particular, not other births to the same mother. The following questions refer to the pregnancy and birth of the child client. Please mark all of the checkboxes that apply for each question, and explain if necessary.

Did the mother have any of the following health problems during pregnancy (mark all that apply)?

☐ Vaginal bleeding
☐ Preeclampsia/Toxemia/Gestational diabetes
☐ Fever/Viral illness/Infection
☐ Trauma/Injury
☐ Iron-deficiency anemia
☐ Severe vomiting
☐ ABO or Rh blood group incompatibility
☐ Preterm labor
☐ Malnutrition or hunger
☐ Lack of prenatal care
☐ Other health problem
☐ None of the Above
☐ Don’t Know/Unsure/Prefer Not to Answer

If you indicated that the mother had any of the above problems—or other health problems—during pregnancy, please explain below:

________________________________________________________________________________________

________________________________________________________________________________________
Did the mother have any of the following experiences during pregnancy (mark all that apply)?
- Exposure to domestic violence
- Experience of stressful or traumatic life events
- Anxiety, depression, or another mental illness or emotional difficulty
- Other experience of major stress or emotional difficulties
- None of the Above
- Don’t Know/Unsure/Prefer Not to Answer

If you indicated that the mother had any of the above experiences during pregnancy, please explain below:

__________________________________________________________________________________________________________________________________________________

Did the mother use or was the mother exposed to any of the following substances during pregnancy (mark all that apply)?
- Alcohol
- Cigarettes or other tobacco products, used by mother
- Cigarettes or other tobacco products, secondhand smoke
- Other illegal drugs or drugs of abuse
- Prescription drugs which may present dangers to pregnancy
- Exposure to other chemicals or teratogenic agents
- None of the Above
- Don’t Know/Unsure/Prefer Not to Answer

If you indicated that the mother used or was exposed to any of the above substances—or other substances—during pregnancy, please explain below:

__________________________________________________________________________________________________________________________________________________

Birth Status:  □ Vaginal  □ C-Section  □ Don’t Know/Unsure/Prefer Not to Answer

Length of Labor: _____ hours

Did the child’s biological mother experience any difficulties or complications before or during labor or delivery with the child client?
- No
- Yes (please explain):

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________________________

If known, what was the child’s birth weight?  _____ lbs, _____ oz
If birth was in a hospital, how long did the mother stay in the hospital after birth? ______ days

If birth was in a hospital, how long did the child stay in the hospital after birth? ______ days

Did the child experience or show any of the following difficulties immediately after birth (mark all that apply)?

- ☐ Birth injury
- ☐ Birth defects
- ☐ Required stay in intensive care/NICU
- ☐ Other difficulty after birth
- ☐ None of the Above
- ☐ Don't Know/Unsure/Prefer Not to Answer

If you indicated that the child experienced or showed any of the above difficulties—or other difficulties—after birth, please explain below:

________________________________________________________________________________________

________________________________________________________________________________________

Did the child’s biological mother ever experience any difficulties during any other pregnancies or deliveries with other children besides the child client?

- ☐ No
- ☐ Yes (please explain):

________________________________________________________________________________________

________________________________________________________________________________________

### Physical and Motor Developmental History

The questions in this section refer to developmental milestones. To the best of your knowledge or recollection, please report when the child client first achieved or accomplished the milestone described. Even if you have a range of dates in mind, try and estimate a specific year and month age. If the child has not reached this milestone, leave the age blank. Additionally, indicate if you recall that this milestone was met early, at a normal time, or late.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Age</th>
<th>Speed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crawling</td>
<td>_____ yr, _____ mo</td>
<td>☐ Early ☐ Normal ☐ Late</td>
</tr>
<tr>
<td>Walked without support</td>
<td>_____ yr, _____ mo</td>
<td>☐ Early ☐ Normal ☐ Late</td>
</tr>
<tr>
<td>Potty-trained during daytime (almost no accidents)</td>
<td>_____ yr, _____ mo</td>
<td>☐ Early ☐ Normal ☐ Late</td>
</tr>
<tr>
<td>Potty-trained during nighttime (almost no accidents)</td>
<td>_____ yr, _____ mo</td>
<td>☐ Early ☐ Normal ☐ Late</td>
</tr>
</tbody>
</table>

Did the child experience any of the following kinds of problems with motor development (mark all that apply)?

- ☐ Clumsy or awkward compared to similarly-aged children
- ☐ Drooling or difficulty chewing and swallowing past infancy
- ☐ Bedwetting, soiling, or daytime accidents past early childhood
- ☐ Trouble acquiring fine motor skills (grasping or manipulating small objects)
- ☐ Poor balance or falling over frequently
- ☐ Required physical or occupational therapy
☐ Other problems with motor development  
☐ None of the Above  
☐ Don't Know/Unsure/Prefer Not to Answer

If you indicated that the child experienced or showed any of the above problems in motor development, or if they achieved any motor developmental milestones late, please explain below:

________________________________________________________

What is the child’s dominant hand (please select one)?
☐ Right  
☐ Left  
☐ Equally both/Ambidextrous  
☐ Don't Know/Unsure/Prefer Not to Answer

■ Cognitive and Language Developmental History

The questions in this section refer to developmental milestones. To the best of your knowledge or recollection, please report when the child client first achieved or accomplished the milestone described. Even if you have a range of dates in mind, try and estimate a specific year and month age. Additionally, indicate if you recall that this milestone was met early, at a normal time, or late. If the child has not reached this milestone, leave the line blank.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Age</th>
<th>Speed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babbled or made word-like noises</td>
<td>______yr, ______mo</td>
<td>Early</td>
</tr>
<tr>
<td>Responded to simple requests (e.g., “pick up the ball”)</td>
<td>______yr, ______mo</td>
<td>Early</td>
</tr>
<tr>
<td>Said first simple words (e.g., “mama, dada, uh-oh!”)</td>
<td>______yr, ______mo</td>
<td>Early</td>
</tr>
<tr>
<td>Said two to four-word sentences</td>
<td>______yr, ______mo</td>
<td>Early</td>
</tr>
<tr>
<td>Played make-believe with dolls or other toys</td>
<td>______yr, ______mo</td>
<td>Early</td>
</tr>
<tr>
<td>Read first book aloud without help</td>
<td>______yr, ______mo</td>
<td>Early</td>
</tr>
</tbody>
</table>

Did the child experience any of the following kinds of problems with cognitive or language development (mark all that apply)?
☐ Diagnosis of mental retardation/intellectual disability  
☐ Trouble with attention or memory  
☐ Trouble with problem-solving  
☐ Trouble learning language  
☐ Using repetitive language (saying same things over and over)  
☐ Uninterested in conversing with others  
☐ Stuttering or other language expression problems  
☐ Required speech therapy  
☐ Other problems with cognitive or language development  
☐ None of the Above  
☐ Don't Know/Unsure/Prefer Not to Answer

If you indicated that the child experienced or showed any of the above problems in cognitive or language development, or if they achieved any cognitive or language developmental milestones late, please explain below:
What languages were spoken in the home during the child client’s childhood?
- English
- Other language(s) (please specify): ____________________________________________

Social-Emotional Developmental History

The questions in this section refer to developmental milestones. To the best of your knowledge or recollection, please report when the child client first achieved or accomplished the milestone described. Even if you have a range of dates in mind, try and estimate a specific year and month age. If the child has not reached this milestone, leave the age blank. Additionally, indicate if you recall that this milestone was met early, at a normal time, or late.

Did the child experience any of the following kinds of problems with social-emotional development (mark all that apply)?
- Prolonged, uncontrollable tantrums
- Inappropriate emotional displays (e.g., laughing or crying at strange times)
- Excessive separation anxiety
- Trouble empathizing with others or hurting others without caring
- Uninterested in social interaction
- Unable to be soothed by parents or caregivers when upset
- Difficulty making friends or getting along with other children
- Selective mutism (refusing to talk to most people or in most settings)
- Displaying very little or no emotion
- Other problems with social-emotional development
- None of the Above
- Don’t Know/Unsure/Prefer Not to Answer

If you indicated that the child experienced or showed any of the above problems in social-emotional development, or if they achieved any social-emotional developmental milestones late, please explain below:

__________________________________________________________________________

__________________________________________________________________________

Check the statements below that describe the type of temperament the child has, or had during childhood (mark all that apply):
- Shy/Timid/Cautious
- Fearful/Anxious
- Stubborn
- Easygoing
- Flexible/Adaptable
- Struggled to adapt to changes
- Disliked being hugged or held
- Upset/Sad
- Affectionate
- Overactive
- Daring/Adventurous
- More interested in things than people
- Quiet/Reserved
- Happy
- Emotional/Emotionally expressive
- More interested in adults than other kids
Educational Information

What grade is the child currently in? If during a summer break, choose the grade most recently completed; if in college, please report the year of study (please select one):

- Pre-K
- K
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- College: _____________

What kind of school does the child attend (please select one):

- Public or Charter
- Private (Secular)
- Private (Parochial/Religious)
- Alternative school
- Don't Know/Unsure/Prefer Not to Answer
- Other (please specify):

Name of Child’s School
__________________________________________

Name of Child’s Homeroom/Primary Teacher/Advisor (If Applicable)
__________________________________________          Phone Number
__________________________________________

Address           City, State, ZIP Code
__________________________________________

Has the child received any kind of special services in school, or has the child in any special placements in school (mark all that apply)?

- IEP
- 504 Plan
- Special Education
- Gifted/Advanced
- Resource
- Assigned a para-professional aide
- Don't Know/Unsure/Prefer Not to Answer
- Other (please specify):

__________________________________________

Please report on the child’s average grades during primary school, middle school, junior high school, high school, and college. If the child has not reached that grade level yet, then simply leave the boxes blank for that column. Please select one response for each column.

<table>
<thead>
<tr>
<th>Primary</th>
<th>Middle</th>
<th>Junior High</th>
<th>High School</th>
<th>College</th>
</tr>
</thead>
<tbody>
<tr>
<td>“A”</td>
<td>“A”</td>
<td>“A”</td>
<td>“A”</td>
<td>“A”</td>
</tr>
<tr>
<td>“B”</td>
<td>“B”</td>
<td>“B”</td>
<td>“B”</td>
<td>“B”</td>
</tr>
<tr>
<td>“C”</td>
<td>“C”</td>
<td>“C”</td>
<td>“C”</td>
<td>“C”</td>
</tr>
<tr>
<td>“D”</td>
<td>“D”</td>
<td>“D”</td>
<td>“D”</td>
<td>“D”</td>
</tr>
<tr>
<td>“F”</td>
<td>“F”</td>
<td>“F”</td>
<td>“F”</td>
<td>“F”</td>
</tr>
</tbody>
</table>
If the child has taken the ACT or the SAT, please report composite scores for these tests:

ACT: _______

SAT: _______

Has the child received special help privately outside of school (e.g., tutoring)? If so, please explain.
☐ No
☐ Yes (please explain):

________________________________________________________________________

________________________________________________________________________

Social History and Functioning

Check the statements below that describe the child’s interactions with peers (mark all that apply):
☐ No friends
☐ Few friends
☐ Friends with a “bad crowd”
☐ Loses/Changes friends quickly
☐ Trouble making new friends
☐ Lots of friends
☐ Has a few very close friends
☐ Manipulative/Cruel/Dishonest
☐ Feels lonely/Isolated from peers
☐ Mean/Aggressive
☐ Shy/Timid/Quiet
☐ Cares too much about peers’ opinions
☐ Show-off/Tries hard to impress others
☐ Bossy/Controlling of others
☐ Roughhouses too much/Too physical with others
☐ Polite/Thoughtful
☐ Inappropriately sexual
☐ Don’t Know/Unsure/Prefer Not to Answer

Is the child involved in any extracurricular activities, such as sports, musical performance or lessons, dance, scouting, 4-H, or others? If so, name which ones.
☐ No
☐ Yes (please explain):

________________________________________________________________________

Life and Family History

Please describe the child’s siblings. For each sibling, mark if they are a biological, step, half, or adopted or foster sibling. Please also fill in each sibling’s first name and age, and select whether you believe the child client’s relationship with that sibling is good, fair, or poor. Finally, check the box at the end if the child lives with that sibling more than half the time.

<table>
<thead>
<tr>
<th>Type</th>
<th>First Name</th>
<th>Age</th>
<th>Relationship</th>
<th>Live With?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Bio ☐ Step ☐ 1/2 ☐ Ad/Fos</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Good ☐ Fair ☐ Poor ☐ Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Bio ☐ Step ☐ 1/2 ☐ Ad/Fos</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Good ☐ Fair ☐ Poor ☐ Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Bio ☐ Step ☐ 1/2 ☐ Ad/Fos</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Good ☐ Fair ☐ Poor ☐ Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Is the child adopted?

- Yes (please answer the follow-up questions under this heading)
- No

When was the child adopted (or began living full-time with current parents)?

- Month
- Year

Is the child aware that he or she is adopted?

- Yes
- No

Is the child in contact with biological parent(s)?

- Yes
- No

Where was the child living before adoption?

- Please briefly describe any information known about the circumstances of the child's living environment or family (or, if adopted at birth, circumstances of the pregnancy) prior to the child's adoption (e.g., child of a teen mother, family member of adoptive parents, in foster homes or residential institution, etc.):

- Please describe current custody or legal guardianship arrangements:

Are the child’s biological parents (or, if adopted, the child’s adoptive parents) separated or divorced?

- Yes (please answer the follow-up questions under this heading)
- No

When did the child’s parents divorce (or first begin living separately)?

- Month
- Year

Has the child experienced any of the following stressful events (mark all that apply)?

- Parent lost job
- Parent frequently away for work
- Starting a new school
- Moving to a new city
- Birth of a sibling
- Sibling left home
- Major accident/Fire/Disaster
- Witnessed abuse/Domestic violence
- Child the victim of a crime
- Family member victim of a crime
- Serious illness or injury of a parent
- Serious illness or injury of a sibling
- Serious illness or injury of an extended family member
- Serious illness or injury of a friend
- Death of a parent
- Death of a sibling
- Death of an extended family member
- Death of a friend
- None of the Above
- Don’t Know/Unsure/Prefer Not to Answer
Psychological History and Functioning

Please indicate if the child has ever been (mark all that apply):
- □ Physically abused
- □ Sexually abused
- □ Emotionally abused
- □ Neglected
- □ Bullied by peers
- □ The subject of any investigation by Child Protective Services or a similar agency
- □ None of the Above
- □ Don't Know/Unsure/Prefer Not to Answer

Has the child experienced any of the following kinds of psychological or emotional problems? Please mark each box that has been an issue for the child beyond what would be expected given the child’s age and developmental level (mark all that apply):
- □ Depression/Sadness
- □ Anxiety or panic attacks
- □ Separation anxiety
- □ Temper tantrums
- □ Excessive irritability
- □ Excessive emotional instability/Mood swings
- □ Aches/Pains/Stomach or digestive troubles that seem to be related to stress or emotion
- □ Difficulty getting to sleep or staying asleep
- □ Tics/Twitches/Repetitive movements
- □ Restricting food/Deliberate vomiting or excessive exercise/Body image concerns
- □ Trouble paying attention, staying on task, or staying organized
- □ Trouble with impulsive behavior or poor decision-making
- □ Oppositional/Defiant to authority or directions
- □ Other psychological problem or issue
- □ None of the Above
- □ Don't Know/Unsure/Prefer Not to Answer

Do you have reason to believe that the child has used or experimented with alcohol or drugs? For each substance, indicate if you believe that the child has never used that substance, or if you are suspicious that they have, or are certain that they have. Please also fill in details for the sections for other drugs or substances, if applicable.

<table>
<thead>
<tr>
<th>Substance</th>
<th>□ Never</th>
<th>□ Suspicion</th>
<th>□ Certain</th>
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<tbody>
<tr>
<td>Alcohol</td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Tobacco/Nicotine</td>
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<tr>
<td>Prescription Med Abuse</td>
<td>□ Never</td>
<td>□ Suspicion</td>
<td>□ Certain</td>
</tr>
<tr>
<td>Drug</td>
<td>□ Never</td>
<td>□ Suspicion</td>
<td>□ Certain</td>
</tr>
<tr>
<td>Drug</td>
<td>□ Never</td>
<td>□ Suspicion</td>
<td>□ Certain</td>
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</table>
This section asks about any thoughts or behaviors related to the child harming him or herself or others. Please report if the child has never had, had in the past, or is currently having these experiences.

- Has the child had or expressed thoughts about wishing he or she were dead, or thinking it would be better if he or she weren’t around? □ Never □ Past □ Currently

- Has the child expressed specific thoughts about killing him or herself? □ Never □ Past □ Currently

- Has the child done things to prepare to kill him or herself, like acquiring pills or weapons, or given things away, or written a note? □ Never □ Past □ Currently

- Has the child made a suicide attempt? □ Never □ Past □ Currently

- Has the child deliberately harmed him or herself without intending to end his or her life (such as by cutting or burning)? □ Never □ Past □ Currently

- Has the child had or expressed urges to physically harm or kill another person? □ Never □ Past □ Currently

Has anyone in the child’s immediate family ever experienced problems with mental illness, or made a suicide attempt, or committed suicide? If so, please explain.

- □ No
- □ Yes (please state which family members)

---

### Mental Health Treatment History

Has the child ever received **therapy or counseling** from a psychologist, therapist, social worker, or counselor?

- □ Yes (please answer the follow-up questions under this heading)
- □ No

If so, how many different times has the child participated in therapy/counseling? _____________

If so, from when to when did the child last participate in therapy/counseling? _______ / _______ – _______ / _______

Has any therapy treatment, at any time in the past, taken place at this clinic? □ Yes □ No

Do you know what “kind” of therapy/counseling was received (e.g., CBT, play therapy, etc.)

________________________________________________________

What was the therapy for—that is, what kinds of problems or issues were addressed?

________________________________________________________
Has therapy/counseling been helpful for the child? □ None □ A little □ Somewhat □ Very

Has the child ever been **prescribed medication** of any kind to help with emotions (like sadness or anxiety), sleep, or attention?
□ Yes (please answer the follow-up questions under this heading)
□ No

If the child has ever taken psychiatric medication of any kind (medication to help with emotions, sleep, or attention), please use the spaces here to describe his or her use of the medication. Record the name of the drug (most drugs have two names—you can put down either one, and guess if you’re not sure), the reason he or she took it, and from when to when (month and year) he or she started and stopped taking it (put “present” if he or she is still taking it).

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Reason</th>
<th>Dates Taken</th>
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Has medication been helpful for the child? □ None □ A little □ Somewhat □ Very

Has the child ever attended any kind of **support group** for a mental health or substance use problem?
□ Yes (please answer the follow-up questions under this heading)
□ No

If so, how many different kinds of groups has the child attended?

If so, from when to when was the child last attending a group?

What were the groups for—that is, what kinds of problems or issues were addressed?

Have support groups been helpful for the child? □ None □ A little □ Somewhat □ Very
Has the child ever **been hospitalized, or received inpatient treatment**, due to a mental health issue?

- [ ] Yes (please answer the follow-up questions under this heading)
- [ ] No

If so, how many times has the child been hospitalized/in inpatient care?  

If so, from when to when was the child last hospitalized/in inpatient care?  

- [ ] / – /  
  
  Month Year Month Year

Why was the child hospitalized or placed in inpatient treatment?

Was inpatient treatment helpful for the child?  

- [ ] None  
- [ ] A little  
- [ ] Somewhat  
- [ ] Very

### Physical Health

**Did the child have access to regular medical care in infancy and childhood?**

- [ ] Yes  
- [ ] No  
- [ ] Don't Know/Unsure/Prefer Not to Answer

**Did the child experience any of the following medical issues during infancy or childhood (mark all that apply)?**

- [ ] Feeding/Gastrointestinal problems  
- [ ] Sleep problems  
- [ ] Cardiovascular problems  
- [ ] Neurological or nervous system or sensory problems  
- [ ] Genitourinary problems  
- [ ] Exposure to lead or environmental toxins  
- [ ] Other medical problems  
- [ ] None of the Above  
- [ ] Don't Know/Unsure/Prefer Not to Answer

If you indicated that the child experienced or showed any of the above feeding or gastrointestinal difficulties—or other difficulties—during infancy, please explain below:

- [ ]

Does the child have any difficulties seeing?  

- [ ] No  
- [ ] Yes (please specify):  

Does the child have any difficulties hearing?  

- [ ] No  
- [ ] Yes (please specify):  

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Child Client Application (Rev. 6/15)
Has the child ever had any of the following experiences or medical issues (mark all that apply)?

- ✔ Stroke
- ✔ Concussion/Knocked out/Traumatic Brain Injury (TBI)
- ✔ Brain Aneurysm
- ✔ Seizure (with or without epilepsy diagnosis)
- ✔ Brain tumor
- ✔ None of the Above
- ✔ Meningitis/Encephalitis
- ✔ Don’t Know/Unsure/Prefer Not to Answer
- ✔ Other neurological issue (please explain):

______________________________________________________________________________

______________________________________________________________________________

About how many hours of sleep does the child you get on an average  weeknight (or, Night before he or she has to wake up on time for work/school/other responsibilities)? ______________________

About how many hours of sleep does the child get on an average  weekend night (or, night before he or she can sleep without needing to get up early)? ______________________

About how long does it take the child to fall asleep on an average night? ______________________

Does the child have difficulties with sleep, like trouble falling asleep or waking up during the middle of the night, or other difficulties like trouble breathing while sleeping, sleepwalking, or having nightmares?

- ✔ No
- ✔ Yes (please explain):

______________________________________________________________________________

______________________________________________________________________________

What was the child’s highest lifetime weight? ______________________ Pounds

What is the child’s current weight? ______________________ Pounds

How tall is the child? ______________________ Feet, Inches

Are you concerned that the child is not eating a healthy diet, or about his or her weight or eating habits?

- ✔ No
- ✔ Yes (please explain):

______________________________________________________________________________

______________________________________________________________________________

When was the last time the child had a checkup or appointment with a physician? __________ / __________ Month Year

Please provide the name, office name, and phone number of the child’s pediatrician or other primary care provider, if he or she has one:

Physician’s Name ______________________

Physician’s Office ______________________

Phone Number ______________________
Please provide the name and contact information for a person you would like to be contacted in case of a medical or other emergency if you or the child’s other custodial parent are not available.

<table>
<thead>
<tr>
<th>Emergency Contact Person’s Name</th>
<th>Relationship with Child</th>
<th>Phone Number</th>
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<thead>
<tr>
<th>Emergency Contact Person’s Full Address, City, State, and ZIP Code</th>
<th>Phone Number (Alternate)</th>
</tr>
</thead>
</table>

Please describe any medical problems or conditions (e.g., cancer, diabetes, epilepsy, high blood pressure, etc.) that the child has, or major illnesses or injuries. Please also describe any kind of treatment (including prescribed or over-the-counter medication or supplements) that he or she may be receiving for them.

<table>
<thead>
<tr>
<th>Medical Condition or Major Illness/Injury</th>
<th>Treatment</th>
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Is the child’s everyday life affected in any way by any of the medical issues described above? If so, please explain.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
Clinician Review and Summary of Client Application:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Reviewing Clinician, Signature  Date

Reviewing Clinician, Print Name

Supervising Clinician, Signature  Date

Supervising Clinician, Print Name