Child's Name ________________________________

Child & Family Services of Saginaw County
2806 Davenport, Saginaw MI
989-790-7500

Please complete form with information about **YOURSELF.**

Your Name ____ Today's Date ______________________

Address ____
Street City State Zip

Home Phone _________________________________ Work Phone ___________________________________

Birthdate ____________________________________ Gender Male Female
(Circle One)

Who to contact in emergency ____

Relationship ____ Phone ______________________________

I am seeking counseling for the following reason(s): ____

____

____

____

Names of individuals to be involved in counseling:

____ ____

____ ____

Method of Payment: Private Pay ______ Insurance _________ Other_________

Child's Name ____________________________________

Please complete the following form as completely and accurately as possible by indicating your response, stating your child's age, or providing explanation for whatever applies to your child. This information is critical in assisting our staff in making an accurate assessment of your child's current need.

Child's Full Name ____ Birth Date _______________________________

Name of Person Completing This Form ____

Relationship to the Child ____

PREGNANCY AND BIRTH

Pregnancy: ☐ planned ☐ unplanned ☐ full term ☐ premature ☐ post mature ☐ illness during pregnancy

Hours of Labor _______________ Delivery: ☐ easy ☐ difficult ☐ instruments used ☐ natural ☐ c-section

Birth Weight _________lbs. _______oz. Length: _______ in. Hospital: __________________________________

Describe any injuries or birth defects: ____

Additional remarks: ____

INFANCY: BIRTH TO ONE YEAR

Breast Fed to Age ____________ Bottle Fed to Age ____________ Weaning: ☐ easy ☐ Hard

Feeding Problems: ☐ colic ☐ spasms ☐ sensitivities ☐ vomiting ☐ constipation ☐ diarrhea

My Child Was Described As: ☐ active ☐ inactive ☐ good natured ☐ cranky ☐ irritable ☐ head banging ☐ crying ☐ restless ☐ difficult to manage ☐ rocking ☐ fearful ☐ fretting

Sleeping Problems ☐ No ☐ Yes Describe: ____

Describe Your Child's Behavior ____

____

Is your child current on all required immunizations? ☐ Yes ☐ No If no please specify ___________________________

____

TODDLER: ONE TO THREE YEARS

Walked Alone at Age _________ First Words _________ Sentences ___________

Eating Difficulties ☐ No ☐ Yes Describe: ____

Toilet Training: Bowel – Started ________ Finished ________ Bladder – Started _______ Finished ________

Describe Your Child's Behavior ____

____

Is your child current on all required immunizations? ☐ Yes ☐ No If no please specify ___________________________

____

Child's Name ___________________________________

PRESCHOOL: THREE TO FIVE YEARS

Day wetting to age: ________________ Temper tantrums: ______________________________

Night wetting to age: ______________ Notable fears: ______________________________

Bowel soiling to age: ______________ General mood: ______________________________

Thumb sucking to age: ______________ Social, shy: ______________________________

Eating difficulties: ____

Sleep difficulties: restless, sleep talking, sleep walking, nightmares, age:______________________________

Is your child current on all required immunizations? ☐ Yes ☐ No If no please specify ____________________

____

PRESCHOOL EXPERIENCES:

Name of Preschool: ____ Age:________________

Describe your child's behavior: ____

____

Difficulties with teacher(s) ☐ Yes ☐ No, peer(s) ☐ Yes ☐ No, group setting ☐ Yes ☐ No

Describe difficulties ____

Is your child current on all required immunizations? ☐ Yes ☐ No If no please specify ____________________

____

CHILDHOOD: FIVE TO TWELVE YEARS

Response to separation: ____

Relationship with peers: ____

School performance: ______________________ Learning difficulties: ______________________

Describe your child's behavior: ____

____

Is your child current on all required immunizations? ☐ Yes ☐ No If no please specify ____________________

____

ADOLESCENCE: THIRTEEN TO EIGHTEEN YEARS

Relationship with peers: ____

School performance: ______________________ Learning difficulties: ______________________

Dating experiences: ☐ Never, ☐ Seldom, ☐ Often, Sexually active: ☐ Yes, ☐ No, ☐ Unknown

Child's Name ___________________________________

Drug usage: ☐ Never, ☐ Experimentation, ☐ Weekends, ☐ Daily, ☐ In Drug Treatment

Job Experiences: ____

Describe your teen's behavior: ____

____

Is your child current on all required immunizations ☐ Yes ☐ No If no please specify ___________________

____

MEDICAL HISTORY

Has your child experienced any of the following: *(please check)*

Yes	*Age*		*Yes*	*Age*		*Yes*	*Age*	
		Allergies			Fainting Spells			Rheumatic Fever
		Asthma			Food Sensitivities			Diabetes
		Bowel Problems			Frequent colds			Ear Infections
		Convulsions			Hearing Problems			Eating Problems
		Delirium			Staring Spells			Epilepsy
		High Fevers			Tubes in Ears			Sexually Transmitted Diseases
		Hives			Weight Problem			Other:
		Eye Problems			Pneumonia			Other:

List of any medications the child is taking, even if only occasionally:

Name of Medication	*Dosage*	*Reason for Taking*

Onset of pubescent body changes: (e.g. menstruation, voice change, secondary hair growth, etc) _______________

____

Accidents: Types and Age: ____

Operations: Types and Age: ____

Other Hospitalizations: Types and Age: ____

Since your child's birth has your family experienced:

Yes	*Age*		*Yes*	*Age*		*Yes*	*Age*	
		Acute Illness			Incest			Substance Abuse/Dependency
		Chronic Illness			Marital Discord			Suicide or Attempt
		Death			Move of Residence			Violence
		Employment Changes			(Re) Marriage			Other:
		Family Financial Stress			Separation or Divorce			Other:

Please elaborate on any box marked: ____

____

____