LIFE COAST COMMUNITY HEALTH CENTER
BEHAVIORAL HEALTH CHILD CLIENT QUESTIONNAIRE

Date: _____

Child's Name: _____ DOB: _____

Race: _____ Sex: □ Male □ Female Gender Identity: _____

Address: _____ City: _____ Zip Code: _____ Parish: _____

Primary phone: _____ Work phone: _____ Other: _____

Legal Parent(s) or Guardian(s) name(s): _____ Education: _____

Child in custody of: □ biological parents □ single biological parent □ adoptive parents □ foster parents
□ state custody □ family with no legal custody

Biological parents' marital status: □ Married □ Never Married □ Separated □ Divorced □ Widowed

What is your preferred language: _____ Do you need an interpreter? □ Yes □ No

Can you read and write: □ Yes □ Need help □ No Do you need printed material in another language? □ Yes □ No

Child's School: _____ Grade: _____ Is there an IEP or 504 Plan? □ Yes □ No

Reason for visit: _____

_____

SCHOOL PROBLEMS: Has the child ever repeated a grade? □ Yes (what grade(s) _____ □ No

Has the child ever been suspended/expelled/asked to leave from school/preschool? □ No □ Yes (explain) _____

_____

Has the child had problems with attendance or tardiness? □ No □ Yes (explain) _____

Briefly describe any difficulties the child is having in school and when they started: _____

_____

Has the child ever had an educational evaluation? If so, where and when? _____

Family history of problems with learning, mental health, alcohol/drug abuse by child's parents or siblings? (explain)

_____

Please list all adults and children living in the home and their age: _____

_____

PRE-NATAL CARE: Age of mother when pregnant: _____ Did mother receive prenatal care? □ Yes □ No

Any complications during pregnancy? (explain) _____

BIRTH HISTORY: □ Child was full-term □ Premature by _____ weeks *Child's birth weight? _____

Any labor or birth complications? (explain) _____

DEVELOPMENTAL HISTORY - Give the approximate age when the child achieved the following:

First began to crawl:	Toilet trained during day:
First walked alone:	Toilet trained during night:
Began using single words:	Could feed self with no help:
Began using understandable phrases:	Could put on/take off clothes by self:

Any other concerns about the child's development? (explain) _____

Does the child have a Primary Care Physician (PCP)? □ Yes (Name: _____) □ No

Child's Name: _____ DOB: _____

CHECK ONLY ONE:

□ **I have signed an Authorization to Receive/Release Protected Health Information (PHI) (Parent/Guardian Initials _____)**

□ **I have signed a Refusal/Revocation of Authorization to Receive/Release PHI (Parent/Guardian Initials _____)**

Current Medication(s)	Purpose	Dose	Times per day	How long on medication?

MEDICAL HISTORY: (Check any that apply for current or past)

□ Surgeries □ Asthma □ Chronic ear infections □ Glasses/Vision problems □ Hearing problems/hearing aids □ Seizures
□ Orthopedic braces □ Serious Injuries □ Head Injuries □ Food allergies □ Medication allergies

_____

□ Neurological Problems □ Cerebral Palsy □ Down's Syndrome _____

Hospitalizations: _____

Prior Diagnosis: _____

List other physicians/clinics/agencies involved with the child: _____

_____

Has the child received counseling or had a psychological evaluation at a hospital, mental health center?

Name of counselor/psychologist	Clinic/facility	Date(s)	Reason for treatment/evaluation

List names of programs and people that have worked with or are currently working with the child (such as speech, OT, PT, etc.)

Name of Program	Type of Service	Name of therapist or provider	Date(s)

Check any significant disruptions the child may have experienced within the past year:

___ Divorce/Separation of parents ___ Parent re-married ___ Moving ___ Death of pet

___ Changed Schools ___ Friend moved away ___ Illness in family (explain) _____

___ Parent lost job or financial condition changed ___ Death (explain) _____

___ Family member/child in trouble with the law (explain) _____

___ Child a victim of abuse or violence (explain) _____

Other: _____

About how many hours of sleep does the child gets per weeknight? _____ hrs / weekend? _____ hrs

Specific sleeping problems? _____

Child's hobbies/interests: _____

Please list 3 things your child does well (can be related to academics, social, behavior) _____

_____

Child's Name: _____ DOB: _____

Religion/Spirituality:

A. Does the child belong to a religious community?	□ **YES** □ **NO**
B. Does the child pray or meditate?	□ **YES** □ **NO**
C. Does the child go to religious services?	□ **YES** □ **NO**

Financial/Transportation:

A. Housing Situation: □ Permanent □ Temporary □ Homeless				
B. Living Conditions (check all that apply): □ Safe □ Unsafe □ Unclean □ Crowded □ Needs repair				
C. In your neighborhood is there: □ Violence □ Crime □ Drugs □ Unsafe Conditions				
D. Do you have running water?	□ **YES** □ **NO**		H. Do you have electricity?	□ **YES** □ **NO**
E. Do you have cooling and heating?	□ **YES** □ **NO**		I. Do you have adequate food?	□ **YES** □ **NO**
F. Can you get medical treatment if needed?	□ **YES** □ **NO**		J. Can you afford needed medication?	□ **YES** □ **NO**
G. Do you have reliable transportation?	□ **YES** □ **NO**		K. Are you able to care for dependents	□ **YES** □ **NO**
How do you usually travel? □ Personal vehicle □ Family/Friends □ Medicaid transportation □ Council on Aging □ Other _____				

Has the child demonstrated any of the following? (Explain)

☐ Persistent sadness — two or more weeks _____

☐ Withdrawing from or avoiding social interactions _____

☐ Hurting oneself or talking about hurting oneself _____

☐ Talking about death or suicide _____

☐ Outbursts or extreme irritability _____

☐ Out-of-control behavior that can be harmful _____

☐ Drastic changes in mood, behavior, or personality _____

☐ Changes in eating habits _____

☐ Loss of weight _____

☐ Difficulty sleeping _____

☐ Frequent headaches or stomachaches _____

☐ Difficulty concentrating _____

☐ Changes in academic performance _____

☐ Avoiding or missing school _____

This form was completed by: _____ Date:_____