



BEHAVIOR CARE SPECIALISTS

Changing Behavior, Changing Lives

CLIENT INFORMATION SHEET

UPDATED SEPTEMBER 2016

Date: _____

CHILD AND FAMILY INFORMATION

Client Information

Last Name:	Age:	Gender:
First Name:	Date of Birth:	Grade:
Street Address:		
City:	State:	Zip:
Primary Diagnosis:	Date of Diagnosis:	
Doctor making diagnosis:	Clinic:	
Address:		
Secondary Diagnosis:	Date of Diagnosis:	
Other condition(s):	Date of Diagnosis:	
Legal Guardian Information		
Full Name:	Relationship to Child:	
Address:	City:	State:
Occupation:	Employer:	
Work Phone:	Email:	
Preferred method of contact:		

Additional Legal Guardian Information

Full Name:	Relationship to Child:	
Address:	City:	State:
Occupation:	Employer:	
Home Phone:	Cell Phone:	
Work Phone:	Email:	

Client's Siblings

Name:	Age:	Gender:
Name:	Age:	Gender:
Name:	Age:	Gender:

Emergency Contacts

Name:	Relationship to Patient:	
Home Phone:	Work Phone:	
Cell Phone:	Address:	
Name:	Relationship to Patient:	
Home Phone:	Work Phone:	
Cell Phone:	Address:	

CHILD SCHOOL/PLACEMENT INFORMATION

Type of Organization:		_____ Birth to 3	_____ Agency	_____ School District
Name:				
Address:		City:	State:	Zip:
Phone:		Years attended:	Placement:	
Contact Person:		Contact Phone:		
Contact Email:				

PRIMARY SOURCE OF FUNDING

_____ Insurance _____ Private Pay _____ Other:				
Insurance Carrier:			Phone:	
Member ID:		Group #:		
Policy Holders Name:		DOB:	SSN:	
Relationship to Patient:				
Address:				
Name of Employer:			Phone:	
Email:				

SECONDARY SOURCE OF FUNDING

Type of Funding:		Case Manager:		
Beneficiaries Name:		DOB:	SSN:	
Member ID:		State ID:		
Relationship to Patient:				
Address:				
Name of employer:		Phone:		
Email:				

REFERRAL INFORMATION

Individual making referral:	Agency:
Address:	
Phone:	Email:

MEDICAL INFORMATION

Primary Physician:	Clinic:
Phone:	Fax:
Address:	

Are there medical conditions that need to be considered while delivering treatment (i.e. seizure disorder, heart condition, diabetes, physical disability)? Yes No If yes, please provide specific details:

Does your child have any known allergies or diet restrictions?

Allergies/Dietary Restrictions	Reactions/Symptoms

Is your child on medication?

Type of Medication*	Dosage	Administration Times	Used For

*Additional medications can be attached on a separate sheet of paper

Does your child have an infectious diseases?		
Name of Disease	Symptoms	Treatment/Prevention
Additional Medical Information*:		

*Additional medical information can be attached on a separate sheet of paper

MEDICAL TREATMENT HISTORY	
Medical Specialty/Service:	
Provider:	Dates of Service:
Methods used and response to methods:	
Medical Specialty/Service:	
Provider:	Dates of Service:
Methods used and response to methods:	

DEVELOPMENTAL HISTORY

Please describe anything unusual about the pregnancy and/or birth of your child:

Has your child ever had any seizure activity?

If yes, when?

Does your child appear to lose skills that were previously mastered? Yes _____ No _____

What are your child's sleeping habits like?

What foods does your child typically eat?

What foods does your child have difficulty eating or will not eat?

FAMILY HISTORY

Is there a history of mental health conditions in your family? If yes, please explain:

Are there any religious, cultural, or spiritual factors that may effect services?

What is the primary language for your family?

Please list any other languages spoken at home:

Please describe any legal or custody issues that may impact services:

Any other family history that would be useful for our team members to know:

COMMUNITY RESOURCES

Are you currently using any community resources?

If yes, please list:

CURRENT TREATMENT	
Speech Services	Dates of Service:
Agency:	Provider Name:
Frequency of Services:	Provider Phone:
Provider Email:	
Occupational Therapy	Dates of Service:
Agency:	Provider Name:
Frequency of Services:	Provider Phone:
Provider Email:	
Physical Therapy	Dates of Service:
Agency:	Provider Name:
Frequency of Services:	Provider Phone:
Provider Email:	
Other Services (Behavioral, Mental Health, Counseling)	Dates of Service:
Agency:	Provider Name:
Frequency of Services:	Provider Phone:
Provider Email:	
Other Services (Behavioral, Mental Health, Counseling)	Dates of Service:
Agency:	Provider Name:
Frequency of Services:	Provider Phone:
Provider Email:	

TREATMENT HISTORY		
Type of Service:	Provider:	Dates of Service:
Methods and response to methods:		
Type of Service:	Provider:	Dates of Service:
Methods and response to methods:		
Type of Service:	Provider:	Dates of Service:
Methods and response to methods:		

Please attach a copy of the following documents:

- *Insurance card (front and back)
- *Current diagnosis according to the DSM-V
- *Additional medicines or allergies

Date ____/____/____

Printed Name of Client or Parent/Legal Guardian

Signature of Client or Parent/Legal Guardian

**If the individual being referred is 18 years old or older, he/she must sign above unless guardianship has been established by a parent or another individual. If guardianship has been established, please include a copy of guardianship papers.*

Current Concerns

Please list any concerns related to the following areas:

Academic:

Behavioral:

Communication:

Daily Living Skills:

Medical:

Motor Skills (fine and gross):

Other: