BEHAVIOR CARE SPECIALISTS

Changing Behavior, Changing Lives

CLIENT INFORMATION SHEET

UPDATED AUGUST 2018

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:	
Home Phone:	Cell Phone:	
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? ☐ Yes ☐ No	

Allergies/Dietary Restrictions	Reactions/Symptoms

Is your child on medication? ☐ Yes ☐ No

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? ☐ Yes ☐ No		
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 every had any seizure activity? ☐ Yes ☐ No	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 affect 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? ☐ Yes ☐ No

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

☐ *I understand that by checking this box and entering my name below, this constitutes a legal signature confirming that I have accurately completed the Client Information Sheet to the best of my ability.*

_____

(Parent/Guardian Signature) *(Date)*

_____

(Client Signature, if indicated)* *(Date)*

**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.*

A photocopy or scanned copy of this form shall have the same force and effect as the original.

Current Concerns
Please list any concerns related to the following areas:
Academic:
Behavioral:
Communication:
Daily Living Skills:
Medical:
Motor Skills (fine and gross):
Other: