



Client Information

Dear Parent/Caregiver,

To prepare for your child's medical evaluation, we would like to know about your child's medical and social history. Please answer the following questions as well as you can. Thank you for your cooperation.

Date: _____ Name of person filling out form: _____ Relationship to child: _____

Child's Information:

Legal Name: First _____ Middle _____ Last _____

Date of Birth: ___/___/___ Age: _____ Gender: Male Female Pronoun(s) _____

Adoption Date (if applicable): _____ Sex Assigned at Birth: Male Female

Does the child have disabilities? Yes No If yes, please describe: _____

Child's ethnicity - Check all that apply:

African American Asian Hispanic Native American/Alaskan

Native Hawaiian/Pacific Islander White Other _____

Insurance: OHP None Private: Insurance Provider: _____

Child's Regular Health Care Provider: _____ Date of last visit: _____ Reason: _____

Child's Regular Dental Provider: _____ Date of last visit: _____ Reason: _____

Medical Information:

Pregnancy and Birth History:

Where was the child born? (Hospital, City, State): _____

Was the child born: On time Early (How many weeks?) _____ Birth Weight: _____

How was the child born? Vaginal Cesarean section: (Why?) _____ Unknown

Mother's age at child's birth: _____ Father's age at child's birth: _____

Were there any problems with the pregnancy or delivery? Yes No Unknown

(explain): _____

Did the child go home from the hospital at the regularly scheduled time? Yes No Unknown

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www.kidscenter.org

Did the mother have regular prenatal care? Yes No Unknown

Were any substances used during pregnancy? Yes No Unknown

(check all that apply): tobacco alcohol prescription medications street drugs other:
(explain)_____

Child's Developmental History:

Have there been any concerns about the child's: sight hearing speech

(explain): _____

Have there been any concerns for developmental delays (i.e. walking, talking, toilet training, education)?

Yes No Unknown

(explain): _____

Child's Medical History:

<i>Does the child have or has the child ever had:</i>	Age	Explanation
Hospitalizations/surgeries	_____	_____
Emergency room or urgent care visits	_____	_____
Major injuries/accidents	_____	_____
Stitches/broken bones	_____	_____
Accidental poisonings	_____	_____
Breathing problems or asthma	_____	_____
Heart problems or murmur	_____	_____
Skin disorders (birthmarks, eczema, warts, etc.)	_____	_____
Bruising/bleeding disorder	_____	_____
Scars/burns	_____	_____
Seizures, passing out, neurological problems	_____	_____
Attention deficit or other mental health concerns	_____	_____
Problems with eating: weight gain or loss	_____	_____
Smokers in the home	_____	_____
Concerns for tobacco use by child	_____	_____
Concerns for alcohol use by child	_____	_____

Concerns for street drug use by child _____

Other current or past medical concerns _____

Are there or have there been problems with:

Toilet training _____

Daytime wetting or nighttime wetting _____

Pooping or soiling accidents _____

Chronic constipation or diarrhea _____

Rashes or sores of front/back private areas _____

Bleeding or discharge from front/back private areas _____

Pain or itching of front/back private areas _____

Bladder/kidney/urinary tract infections _____

Past injury to private areas _____

What words does the child use for private areas?

Male front private area: _____ Bottom/buttocks: _____

Female front private area: _____ Chest/breasts: _____

For older girls:

Date of first menstrual period: _____ Date of last menstrual period: _____

Ever missed a period? _____ Use: Pads Tampons Both

Ever experienced a problem with tampon use? _____

Medication/Immunizations:

Are immunizations up to date? Yes No Unknown

Does the child take any medication, supplements, vitamins or fluoride? Yes No Unknown

Medication:	Dose & Frequency:	Reason for Use:	Date/time/last taken:	Prescribed by:
Example: amoxicillin	250 mg twice/day	Ear infection	Yesterday	Dr. John Doe

Allergies:

Any allergies to medication or food? Yes No Unknown

What is the child allergic to and describe reaction: _____

Family Medical Information:

Check any disease(s)/condition(s) that the child's parents, siblings or other family members have or have had:

	<u>Parent</u>	<u>Sibling</u>	<u>Other</u>		<u>Parent</u>	<u>Sibling</u>	<u>Other</u>
Birth defects	_____	_____	_____	Asthma	_____	_____	_____
High Blood Pressure	_____	_____	_____	Seizures	_____	_____	_____
Bleeding problems	_____	_____	_____	Cancer	_____	_____	_____
Frequent broken bones	_____	_____	_____	Depression	_____	_____	_____
Immune disorder	_____	_____	_____	Anxiety	_____	_____	_____
Disability	_____	_____	_____	Drug problems	_____	_____	_____
Learning problems	_____	_____	_____	Alcohol problems	_____	_____	_____
SIDS	_____	_____	_____	Other Mental health problems	_____	_____	_____
Heart disease	_____	_____	_____	ADHD	_____	_____	_____
Diabetes	_____	_____	_____	Self-Harm	_____	_____	_____
Eating Disorders	_____	_____	_____	Suicide Attempts/Completion	_____	_____	_____

Other (describe): _____

Social Information:

Family:

Biological Mother: _____ Birth date: _____

Biological Father: _____ Birth date: _____

Date relationship started: _____ Date relationship ended: _____

Adoptive parent(s)/Guardian(s): _____ Birth date: _____

_____ Birth date: _____

Date relationship started: _____ Date relationship ended: _____

If parents are not together, what is the status of the custody arrangement? Resolved Unresolved In progress

What is the visitation schedule? _____

Brothers/Sisters (including Half and Step Siblings):

Name: _____ Birth date: _____ Mother: _____ Father: _____

Name: _____ Birth date: _____ Mother: _____ Father: _____

Name: _____ Birth date: _____ Mother: _____ Father: _____

Name: _____ Birth date: _____ Mother: _____ Father: _____

Name: _____ Birth date: _____ Mother: _____ Father: _____

Name: _____ Birth date: _____ Mother: _____ Father: _____

Marriages/significant relationships:

For mother:

Name of spouse/partner: _____ Birth Date: _____ Dates: _____

Ever Married? Yes No Dates: _____

Name of spouse/partner: _____ Birth Date: _____ Dates: _____

Ever Married? Yes No Dates: _____

Name of spouse/partner: _____ Birth Date: _____ Dates: _____

Ever Married? Yes No Dates: _____

For father:

Name of spouse/partner: _____ Birth Date: _____ Dates: _____

Ever Married? Yes No Dates: _____

Name of spouse/partner: _____ Birth Date: _____ Dates: _____

Ever Married? Yes No Dates: _____

Name of spouse/partner: _____ Birth Date: _____ Dates: _____

Ever Married? Yes No Dates: _____

Housing:

Current address of child: _____

Who lives here? _____

How long has child lived here? _____

Other addresses for the child: _____

Has the child ever lived in another state? Yes No Unknown

When and where: _____

Has the child ever been homeless or lived in shelters? Yes No Unknown

Age of child _____ Dates: from _____ to _____

Age of child _____ Dates: from _____ to _____

Has the child ever been in foster care or lived with another family? Yes No Unknown

Age of child _____ Dates: from _____ to _____

Age of child _____ Dates: from _____ to _____

Mother's address: _____

Mother's phone number: _____ Cell: _____

Mother's email: _____

Father's address: _____

Father's phone number: _____ Cell: _____

Father's email: _____

Parental/Guardian employment:

Name _____ Job _____ Hrs/days _____ or Unemployed _____

Name _____ Job _____ Hrs/days _____ or Unemployed _____

Abuse history:

Have you or anyone else ever been concerned that this child or siblings have been harmed or mistreated in the past?

Yes No Unknown

(explain) _____

Has either parent or anyone else in the family experienced any type of abuse or neglect (including domestic violence)?

Yes No Unknown

(explain) _____

Has DHS (child protective services) ever been involved with the family? Yes No Unknown

(explain) _____

Has a LEA (law enforcement agency) ever been involved with the family? Yes No Unknown

(explain)_____

Exposure to fighting or violence between adults in the home:

Has there been fighting or violence between the adults in the child's life? Yes No Unknown

(explain)_____

Has the child seen or heard this fighting?_____

Exposure to drugs and/or alcohol:

Is the child exposed to alcohol and/or drugs at home or any other location? Yes No Unknown

(explain)_____

Are alcohol and/or drugs used by family? Unknown No Current Past

(explain)_____

Recovery? Yes No Unknown If yes, for how long?_____

Exposure to sexual material or nudity:

Is there pornography in your home or in a home the child visits? Yes No Unknown

(explain)_____

Has the child been exposed to pornography on TV, movies, videos, magazines and/or computers? Yes No

Unknown (explain)_____

Has the child been exposed to sexual activity or walked in on adults having sex? Yes No Unknown

(explain)_____

Cruelty to animals:

Family history of animal cruelty: Yes No Unknown

(explain)_____

Counseling history:

Has the child ever been in counseling? Yes No Unknown

Reason for counseling_____

Counselor_____Agency/Phone_____Dates_____

Have any other family members been in counseling? Yes No Unknown

Reason for counseling and who attended_____

Counselor _____ Agency/Phone _____ Dates _____

Child's behaviors:

Have you or anyone else been concerned about these behaviors for the child?

Sleep problems or nightmares Never Occasionally Often

Onset: _____ Improving: _____ Worsening: _____

(explain) _____

Fear of people, places, situations Never Occasionally Often

Onset: _____ Improving: _____ Worsening: _____

(explain) _____

Anger or aggression (tantrums, hitting others) Never Occasionally Often

Onset: _____ Improving: _____ Worsening: _____

(explain) _____

Sexualized behavior or play Never Occasionally Often

Onset: _____ Improving: _____ Worsening: _____

(explain) _____

Withdrawal from friends or family Never Occasionally Often

Onset: _____ Improving: _____ Worsening: _____

(explain) _____

Sadness (lasting more than a few hours) Never Occasionally Often

Onset: _____ Improving: _____ Worsening: _____

(explain) _____

Nervous habits (nail biting, picking at skin) Never Occasionally Often

Onset: _____ Improving: _____ Worsening: _____

(explain) _____

Lying Never Occasionally Often

Onset: _____ Improving: _____ Worsening: _____

(explain) _____

Cruelty to animals Never Occasionally Often
Onset: _____ Improving: _____ Worsening: _____
(explain) _____

Playing with matches or fire Never Occasionally Often
Onset: _____ Improving: _____ Worsening: _____
(explain) _____

Hyperactivity/difficulty concentrating Never Occasionally Often
Onset: _____ Improving: _____ Worsening: _____
(explain) _____

Injuries to self or others Never Occasionally Often
Onset: _____ Improving: _____ Worsening: _____
(explain) _____

Eating problems or changes in appetite Never Occasionally Often
Onset: _____ Improving: _____ Worsening: _____
(explain) _____

History of running away Never Occasionally Often
Onset: _____ Improving: _____ Worsening: _____
(explain) _____

Are there any other behaviors of concern? _____

Methods of discipline:

What types of discipline are used with the child?

_____ Rarely Occasionally Often For what behavior(s)? _____

_____ Rarely Occasionally Often For what behavior(s)? _____

_____ Rarely Occasionally Often For what behavior(s)? _____

Child's Education:

Child's school _____ Grade _____ Teacher _____

How is the child doing in school? Above Average Average Below Average Unknown

School attendance: Good Fair Poor Unknown Number of days missed last month_____

Has the child ever been suspended or expelled? Yes No Unknown (explain):_____

Any learning problems? Yes No Unknown (explain):_____

Individualized Education Plan (IEP)? Yes No Unknown (explain):_____

Does the child have difficulties getting along with teachers or adults? Yes No Unknown
(explain):_____

Does the child have difficulties getting along with other children? Yes No Unknown
(explain):_____

Caretakers:

List others who have cared for child (such as babysitters, daycare, and/or relatives):

Name:	Relation:	Dates:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family stressors:

In the past year have there been any significant events or issues affecting the child or family (such as deaths, illnesses, conflict between family members, divorce, job loss, moves)? (explain):

Financial stress: Current Past Both None

Weapons in the home

Are there weapons in the home?_____What Type?_____

Are they secured? Yes No Unknown If yes, how are they secured?_____

For children five (5) years and younger:

Who bathes the child?_____

Who helps toilet the child?_____

Who puts the child to bed?_____

Where and with whom does the child sleep?_____

Additional Information:

Has anyone from the family attended a Darkness to Light training? Yes No Unknown

If yes when: _____

Has the family currently or ever been involved with Mary’s Place for supervised visitation?

Yes No Unknown

If yes when: _____

Demographic Information:

KIDS Center is a non-profit organization dedicated to the prevention, assessment, and treatment of child abuse and neglect. Because we do not charge families for our services, a large percentage of our funding comes from local, state, and federal grants. These grants often require us to provide demographic information (age, race & ethnicity, income levels, etc.) for the families we see. We would appreciate you filling in the following information, as it will assist us in obtaining additional funding so that we can continue to provide the highest level of service to our community. This information will be used for grant writing purposes only, and will remain confidential. Thank you for assisting us.

1. Annual Family Income (before taxes):

- Less than \$12,060 per year (\$1,005 per month)
- \$12,061-\$16,239 per year (\$1,353 per month)
- \$16,240-\$20, 419 per year (\$1,679 per month)
- \$20,420-\$24, 599 per year (\$2,050 per month)
- \$24,600- \$28,779 per year (\$2,398 per month)
- \$28,780- \$32,959 per year (\$2,747 per month)
- \$32,960- \$37,139 per year (\$3,095 per month)
- \$37,140- \$ 41,319 per year (\$3,443 per month)
- \$41,320-\$59,999 per year (\$5,000 per month)
- \$60,000-\$79,999 per year (\$6,666 per month)
- \$80,000- \$99,999 per year (\$8,333 per month)
- More than \$100,000 per year

2. Number of people supported by the income listed above? _____

I certify that the above information is true and correct to the best of my knowledge. I will notify KIDS Center promptly of any changes in the above information.

_____ /_____/_____
I hereby swear I am the legal Custodian of child Date

_____ /_____/_____
Foster Parent Signature Date

Consent for follow-up contact:

I give my consent for follow-up contact through telephone calls or letters by KIDS Center staff after I have completed services at KIDS Center. I understand that I can cancel this consent at any time through a verbal request.

_____ / ____ / ____
I hereby swear I am the legal Custodian of child Date

Feedback Procedure:

KIDS Center wishes to provide high quality service, therefore, suggestions for improvement of, or complaints about services are welcomed. If you have a concern or suggestion regarding services, you are encouraged to discuss this concern with the professional providing service or KIDS Center’s Executive Director. Positive feedback is also encouraged.

In accordance with Federal law and U.S. Department of Justice policy, this organization is prohibited from discriminating on the basis of race, color, national origin, disability, religion, sex, or age.

To file a complaint of discrimination, write Office of Civil Rights, Office of Justice Programs, U.S. Department of Justice (OCR), 810 7th Street, NW, Washington, DC 20531 or call 202-307-0690 (Voice) or 202-307-2027 (TDD/TTY). Individuals who are hearing impaired or have speech disabilities may also contact OCR through the Federal Relay Service at 800-877-8339 (TTY), 877-877-8982 (Speech) or 800-845-6136 (Spanish).

Availability of Interpreter Services:

KIDS Center provides translation services, free of charge, to clients who do not speak English. If you need assistance, please let a member of staff know that you need an interpreter.