CHILD FOCUS, INC.
Child Registration

Office Use Only (Registration Worker)

Registration Date:		1st Intake Appointment Offered:			
		Fee Code (Medicaid, Private Insurance Company, Fee):			
911/DI Worker:	DATE:				
		Case #:			
			Therapy		Group:
			Diagnostic Testing		CPST
			Partial Hospitalization		Juvenile Court Intensive HB
			Therapeutic Foster Care		Psychiatric Evaluation
			School Contract Therapy (Program 76)		Other:
Legal Custodian of Client:					

PLEASE PRINT - Please read and fill out ALL sections.

Child's Information		
Last Name:	First Name:	Middle Name:
Nickname(s):	Sex:	SS#:
	Age:	DOB:
Primary Language if other than English:		

Name of School that Child Attends:		**Current Grade in School:**	

	Child's Race: (Check All that apply):
	Asian (A)
	Black/ African American (B)
	Alaskan Native (M)
	Native American/American Indian (N)
	White (W)
	Native Hawaiian / Other Pacific Islander (P)

	Child's Ethnicity: (Check All that apply):
	Puerto Rican (A)
	Cuban (C)
	Mexican (B)
	Other Hispanic (D)
	Not Hispanic or Latino (E)

Guardian(s) / Legal Custodian(s) Information:		
Name:		SS#:
Street Address:		DOB:
Mailing Address:		
City:	State:	Zip:
Home #:	Work #:	Cell #:
Email address:		
Relationship to Child (mother, father, parents, or other – specify):		
Military Status: (Specify) No or Yes	Active or Inactive	

Client Name: ______________________________

Type of Custody: (Place a check next to the type of custody)					
	Both Parents Still Together		Joint Custody		Temporary Custody
	Residential Parent		Shared Parent		Other (*specify*):

If this is the same as page 1, check this box ☐ and skip to next section.	Person who Child Resides with / Foster Parent / Relative Information:		
	Name:		
	DOB:		
	Street Address:		
	Mailing Address:		
	City:	State:	Zip:
	Home #:	Work #:	Cell #:
	Relationship to Child (foster parent or other – specify):		
	Military Status: (Specify) No or Yes	Active or Inactive	

If this is the same as page 1, check this box ☐ and skip to next section.	Parent Information (Mother):		
	Name:		
	DOB:		
	Street Address:		
	Mailing Address:		
	City:	State:	Zip:
	Home #:	Work #:	Cell #:
	Military Status: (Specify) No or Yes	Active or Inactive	

If this is the same as page 1, check this box ☐ and skip to next section.	Parent Information (Father):		
	Name:		
	DOB:		
	Street Address:		
	Mailing Address:		
	City:	State:	Zip:
	Home #:	Work #:	Cell #:
	Military Status: (Specify) No or Yes	Active or Inactive	

Person to Contact in Case of Emergency:	
Name:	Phone#:

List Names and Age of Child's Siblings and Other Persons Living in the Home:			
Full Name:	**Age:**	**Relation:**	**Sibling Lives Elsewhere? Y or N**

What is your family's gross annual income? ______________________________

Client Name: ______________________________

Child's Current Home Is:					
	Biological Parent's Home (A)		Crisis Residential (D)		Adoptive Parent's Home (U)
	Friend's Home (B)		Foster Care (H)		
	Other Relative's Home (C)		Homeless (S)		

Who referred you Child Focus? (*check only one*)	
	Self (A)
	AOD Abuse Care Provider (B)
	MH Provider (C)
	Dual Providers (D)
	Other Health Care Provider (E)
	School / Education (F)
	EAP / Employer (G)
	County Human Services (H)
	Other Community Referral (I)
	State / Federal Court (J)
	Municipal Court (K)
	Common Pleas Court (L)
	Juvenile Court (M)
	Diversionary (N)
	Prison (O)
	Other Criminal Justice (P)
	Forensic (Q)

Name of Person or Agency that referred you to Child Focus:
Phone Number of Person or Referring Agency:

Child's Education Program/Type (*check only one*)	
	Regular Education (1)
	ED (Emotional Disturbance) (2)
	SLD (Specific Learning Disability) (3)
	Hearing Impairment (4)
	Visual Impairment (5)
	Multiple Disabilities (6)
	Cognitive Disability (7)
	Autism (8)
	Orthopedic Impairment(9)
	Other (specify) (10):

Child's Mental Health History
Has your child ever had psychological testing or counseling? ☐ **Yes** ☐ **No**
If yes, please explain:

Is your child currently on probation? ☐ **Yes** ☐ **No** **If yes, explain below:**

Does your child have a disability? ☐ **Yes** ☐ **No** **If yes, explain below:**

Client Name: ______________________________

PLEASE HELP US TO BETTER UNDERSTAND YOUR NEEDS AND PREFERENCES:

Is your child *currently* suicidal? ☐ YES ☐ NO **Is your child *currently* homicidal?** ☐ YES ☐ NO

If yes, explain: ____

Do you prefer a male or female service provider? ☐ MALE ☐ FEMALE ☐ EITHER

Are you willing to attend appointments *earlier* than 4 p.m.? ☐ YES ☐ NO

Would you like your child to attend group treatment? ☐YES ☐ NO ☐ UNSURE

If yes, which group? ____

Are you seeking psychiatry (e.g., medication) services? ☐ YES ☐ NO ☐ UNSURE

What is bringing you here today? Please explain your child's current issues in writing and your service provider will review what you have written.

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______________________________________ ______________________________

Parent / Guardian Date

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Action taken if child is suicidal/homicidal:

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	DSM IV Code	DSM IV Diagnosis
Dx1		
Dx 2		

Child's Global Assessment Score (1-100):_______________ Duration: _______________months

Date/Time Ongoing Appt. 1st offered	Date/Time Ongoing Appt. Scheduled	Entered into Catt
		☐ Offered ☐ Seen

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Prioritize Areas of Need (1-3)

	01 ADHD		08 Eating Disorders		16 Oppositional Defiant		30 Physical Abuse		66 Self-Esteem Issues
	02 Aggressive		09 Encopresis		17 JC Involvement		35 Pregnancy		70 Sex Abuse Offender
	03 Alcohol/Drug Use		10 Enuresis		19 Panic Attack		40 Psychophysiological		71 Sex Abuse Victim
	04 Animal Torture		11 Firesetter		20 Parenting Problems		50 Runaway		72 Sexual Acting Out
	05 Anxiety		12 Grief Reaction		21 Homicidal		60 School Refusal		80 Suicidal
	06 Depression		13 Hallucination – Auditory		22 Pervasive Dev D/O		61 School Problems		81 Trichotillomania
	07 Divorce Issues		14 Hallucination – Visual		25 Phobia		65 Self-Abuse		90 Truant