

Client Name: _____



Child Registration

Office Use Only (Registration Worker)			
Date Registration Submitted to Office:		1 st Intake Appointment Offered:	
		Fee Code (Medicaid, Private Insurance Company, Fee):	
g11/DI Worker:	DATE:		
		Case #:	
		Therapy	Group:
		Diagnostic Testing	CPST
		Day Treatment	Juvenile Court Intensive HB
		Therapeutic Foster Care	Psychiatric Evaluation
		School Contract Therapy (Prgm 76)	Other:
Legal Custodian of Client:			

PLEASE PRINT - Please read and fill out ALL sections.

Child's Information

Legal Name (last, first, middle):		Preferred/Chosen Name:
Pronouns:	Gender:	Sex assigned at birth:
SS#:	Age:	DOB:
Primary Language if other than English:		

Name of School that Child Attends:	Current Grade in School:
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Child's Race: (Check All that apply):

<input type="checkbox"/>	Alaskan Native
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Black/ African American
<input type="checkbox"/>	Native American/American Indian
<input type="checkbox"/>	Native Hawaiian / Other Pacific Islander
<input type="checkbox"/>	White
<input type="checkbox"/>	Biracial:

Child's Ethnicity: (Check All that apply):

<input type="checkbox"/>	Cuban
<input type="checkbox"/>	Mexican
<input type="checkbox"/>	Puerto Rican
<input type="checkbox"/>	Other Hispanic
<input type="checkbox"/>	Not Hispanic or Latino

Guardian(s) / Legal Custodian(s) Information:

Name:		Pronouns:
Street Address:		DOB:
Mailing Address:		County of Residence:
City:	State:	Zip:
Home #:	Work #:	Cell #:
Email address:		SS#:
Relationship to Child (mother, father, parents, or other – specify):		
Military Status: <input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____ <input type="checkbox"/> Active <input type="checkbox"/> Inactive		

Client Name: _____

Type of Custody: (Place a check next to the type of custody)

<input type="checkbox"/>	Both Parents Still Together	<input type="checkbox"/>	Joint Custody	<input type="checkbox"/>	Temporary Custody
<input type="checkbox"/>	Residential Parent	<input type="checkbox"/>	Shared Parent	<input type="checkbox"/>	Other (specify):

Person who Child Resides with / Foster Parent / Relative Information:

☐ If this is the same as page 1, check this box and skip to next section.

Name:

DOB:

Street Address:

Mailing Address:

City:

State:

Zip:

Home #:

Work #:

Cell #:

Relationship to Child (foster parent or other – specify):

Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive

Biological Parent Information:

☐ If this is the same as page 1, check this box and skip to next section.

Biological Parent 1:

Pronouns:

Phone #:

Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive

Relationship to Child:

Biological Parent 2:

Pronouns:

Phone #:

Military Status: ☐ No ☐ Yes (specify): _____ ☐ Active ☐ Inactive

Relationship to Child:

Person to Contact in Case of Emergency:

Name:

Pronouns:

Relationship:

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? _____

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

Name:

Phone #:

Other Community and Human Service Providers Involved

Contact Name and Phone Number

Client Name: _____

(check all that apply):	
<input type="checkbox"/>	Children's/Job and Family Services
<input type="checkbox"/>	Domestic Relations Court / Other Court
<input type="checkbox"/>	Mental Health or other Health
<input type="checkbox"/>	Juvenile probation
<input type="checkbox"/>	County DD
<input type="checkbox"/>	Other (specify):

Child's Mental Health History
Has your child ever had psychological testing or counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain:

Is your child currently on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain below:

Is your child living with disabilities? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain below:
Is service animal assistance needed for a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what tasks is the service animal trained to perform? Explain below:	

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 any preferences regarding your provider?

If yes, explain: _____

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

At this time, I prefer ☐ In person services ☐ Telehealth services (via secure video conferencing)
☐ No preference, either is fine

What is bringing you here today? Please identify your child's current needs in writing. Your service provider will review what you have written so a detailed description is most helpful in assuring your needs are met.

Client Name: _____

Severity of Current Needs:

1	2	3	4	5	6	7	8	9	10
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Very little impact on functioning

Extreme impact on functioning

Please rate environmental supports for change

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Very little support

Much support

Client motivation to change

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Very little motivation

Very high motivation

Parent / Guardian

Date

Office Use Only (Clinician)

Action taken if child is suicidal/homicidal: _____

Office Use Only for Crisis Services and/or Diagnostic Testing (Clinician)

	ICD 10 Code	DSM V Diagnosis
Dx1		
Dx 2		

Date/Time Ongoing Appt. 1 st offered	Date/Time Ongoing Appt. Scheduled	Entered into Catt
		<input type="checkbox"/> Offered <input type="checkbox"/> Seen