Child/Adolescent Psychiatry Clinic
701 Park Avenue – R7.255
Minneapolis, MN 55415
Phone (612) 873-2617
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HennepinHealthcare

Child and Family Information Form

Child's legal name: ___________________________

Child's chosen name: _________________________ Child's pronouns: ____________________

Person completing this form: ____

Relationship to the child: ____

Service Requested (check all that apply): Evaluation: ____ Therapy: ____ Medication: ________

Person who referred you to this clinic: ____

Relationship to the child: ____

Language(s) spoken by child/caregivers: ____

Custody

Who has legal custody of the child: ____

Telephone number(s): H:________________ W:_________________ C:___________________

Address (if different from child's): ____

City: ____________________ State: ____________________ Zip code: ___________________

Registration Information

Child's Current Address: ____

City: ____________________ State: ____________________ Zip code: ___________________

Child lives with (check all that apply): Mother(s): ____ Father(s):____ Adoptive parent(s):____
Other (please explain): ____________________________________

If the child is not living with both parents, please explain: _______________________________

____

If the child has a parent not living with the child, are there visitations? Yes: ____ No: _____

Parent/Caregiver's Information

Caregiver 1's name: ____

Telephone number(s): H: ________________ W:_________________ C:___________________

Address (if different from child's): ____

City: ____________________ State: ____________________ Zip code: ___________________

Caregiver 2's name: ____

Telephone number(s): H:________________ W:_________________ C:___________________

Address (if different from child's): ____

City: ____________________ State: ____________________ Zip code: ___________________

Other parent/caregiver name(s): ____

Telephone number(s): H:________________ W:_________________ C:___________________

Address (if different from child's): ____

City: ____________________ State: ____________________ Zip code: ___________________

Foster Parent or Other Current Primary Caregiver, if applicable

Name: ____

Telephone number(s): ________________________ Relationship: _______________________

Back-up Emergency Contact

Name: ____

Telephone number(s): ________________________ Relationship: _______________________

School Information

School name: ____

City: ____________________ Telephone number: ________________ Child's Grade: _______

Teacher's name and email address: ____

School Counselor/Social Worker name and email address (if applicable):

____

Family and Home Information

All people currently living with the child:

Name	Birth Date	Age	Relationship
___________________________	______________	_____	______________________
___________________________	______________	_____	______________________
___________________________	______________	_____	______________________
___________________________	______________	_____	______________________
___________________________	______________	_____	______________________

Has your child had any long separations from any parents or siblings? Yes: ______ No: _______

If "yes," please explain: ____

Has your child or family experienced any traumatic or very scary events? Yes: ______No:_____

If "yes," please explain: ____

Has your family ever experienced domestic violence? Yes: ______ No: _______

To your knowledge, has your child ever been physically abused? Yes: ______ No: _______

To your knowledge, has your child ever been sexually abused? Yes: ______ No: _______

Has your family ever been involved with Child Protective Services Yes: ______ No: _______

If "yes," please explain: ____

Has there been a time in the last 12 months when your family did not have enough money to buy food or food to eat? Yes: ______ No: _______

Child's Developmental History

Were there any problems during pregnancy or delivery? Yes: ______ No: _______

If "yes," please explain: ____

Was the baby exposed to nicotine, marijuana, drugs (prescribed as well as non-prescribed, or alcohol at any point in the pregnancy? Yes: ____ No: ___

If "yes," please explain: ____

At what age did your child: Walk: ________ Say 1st words: ______ Fully toilet trained: _______

Were there any difficulties or delays? Yes: ______ No: _______

If "yes," please explain: ____

Are there any problems now with bedwetting/accidents? (Check all that apply)

Daytime accidents: ______ Nighttime accidents: ______ No accidents: ________

Was your child adaptable, easy to soothe, easy to please and/or easy to discipline? Yes:__No:__

Has your child been referred for/or participated in any special programs? Yes: _____ No: _____

Child's Medical History

Clinic where your child receives primary care: ____

Primary care provider's name: ____

Does your child have allergies to food or medication: Yes: ______ No:_______

If "yes," to what does your child have allergies? _______________________________________

Please list any current or past health problems, hospitalizations or surgeries your child has had:____

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Please circle if your child has a history of the following conditions:

Head Injury Loss of Consciousness Seizure

Please circle if your child CURRENTLY has a problem with one of the following:

Pain Eating Sleeping

Please list any medications your child is currently taking:

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Please list any previous mental health services (therapy, evaluation or medication) your child has received:

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Family Mental Health History

Illness or Problem	Biological Mother	Biological Father	Adoptive Parent	Adoptive Parent	Biological Sister or Brother	Other Relative
Depression						
Bipolar Disorder						
Suicide Attempt						
Anxiety						
Schizophrenia						
Autism Spectrum Disorder						
Learning Problem						
Behavior Problem						
Attention Problem						
Alcohol/Drug Problem						
Other						

Please describe your concerns about your child (emotions, behavior, learning, getting along with people, etc.):

Please list your child's strengths:

Please describe any identity information that are important in the care of your child (cultural, religious, gender, sexual orientation, ethnicity, race, etc.):

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Please list any potential barriers to establishing care or any supports that will help you maintain consistent care:

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