Application and History For Minor Child
COMPLETED BY PARENT/GUARDIAN

Who referred you to Alpert Jewish Family Service?_____

Personal Information:

Please print clearly. Complete as much information possible. This information will be discussed with your counselor.

Today's Date:_____

Child's Name:_____

Child's Date of Birth:_____

Your Name:_____ Date of Birth:_____

Age:_____ Gender: **M** **F**

Do you have legal custody of child/adolescent? **Yes** or **No**

Your address_____

Child's address (if different):_____

Home Phone ( ) _____ Cell Phone ( ) _____

May we leave a message on your voicemail: At Home: Yes No **On Cell:** Yes No
(Please Circle One)

Race: Black Asian Biracial Hispanic White

Ethnicity: Non-Hispanic Haitian Hispanic Other _____

Marital Status: Single Divorced Married Separated Widowed
*If Divorced or Separated, do you share legal custody of child/adolescent? Yes or No

Religion: Christian Jewish Muslim Other_____

Employment Status: Employed full time Not employed Employed part-time
Retired Student

Primary Language: English Creole Russian Spanish Other_____

Live with: Adult child Parents Father only Group Home Alone
Mother only Significant Other Spouse Children Only
Other_____

Non-home setting: Alf/nursing home Group Home Other

Gross Annual Family Income:_____

Total Adults in Home:_____ Total Children in Home:_____

Number of years of Education: _____

Who may we contact in case of emergency? Name:_____ Phone:_____

Family Information:

List the current members of the child/adolescent's household-Include ages and relation to the child:

Father:_____
( ) Biological ( ) Step ( ) Foster ( ) Adopted Age Address/Phone (if different from child's)

Occupation_____ Does this parent have legal custody of child/adolescent? Yes No

Mother:_____
( ) Biological ( ) Step ( ) Foster ( ) Adopted Age Address/Phone (if different from child's)

Occupation_____ Does this parent have legal custody of child/adolescent? Yes No

Is there a biological parent living outside the home? Yes or No

_____
Name Age Occupation Address

Other Children: (in chronological order)

_____
Name/age ( )Biological ( )Step ( ) Foster ( ) Adopted Address (if not same)

_____
Name/age ( )Biological ( )Step ( ) Foster ( ) Adopted Address (if not same)

_____
Name/age ( )Biological ( )Step ( ) Foster ( ) Adopted Address (if not same)

_____
Name/age ( )Biological ( )Step ( ) Foster ( ) Adopted Address (if not same)

Others living in the home_____

Marital Status of the Parent:

Current Marriage: Give Date of: Marriage:_____ Years Together:_____

Prior: Mother: Separated:_____ Divorced:_____ Widowed:_____

Father: Separated:_____ Divorced:_____ Widowed:_____

Educational Information:

Current School:

Name:_____ City:_____

Grade:_____Type of Class: Regular_____ Other_____

Name of Guidance Counselor: _____ Teacher:_____

How long has your child attended this school? _____

Additional Information regarding educational history:_____
_____
_____
_____
_____

Medical Information

Please list any past or current mental health professionals or medical doctors you have seen and indicate whether we may contact them:

Name of Professional	**Specialty**	**Phone #**

Medications

Please list any medications/ supplements/vitamins/ or over the counter prescriptions that you are taking. Please attach additional paper if needed.

Medications/ Supplements/ Vitamins/ Over the counter preparations	Amount	Frequency

Has your child/adolescent ever been hospitalized, received surgery, sustained serious injuries, broken bones, head injuries etc.? _____

_____

Does the child/adolescent have allergies?_____

_____

Is the child/adolescent taking prescription medicine?_____

_____

Does your child suffer from: (Explain if yes)

Hearing problems Yes No
Vision Problems Yes No
Speech Problems Yes No

SLEEP PATTERNS: (Explain if yes)

Past sleep problems?	yes	no	Current sleep problems?	yes	no
Problems falling asleep?	yes	no	Problems staying asleep?	yes	no
Waking too early?	yes	no	Frequent dreams/nightmares?	yes	no

Does your child have trouble sleeping alone? Yes No
Is your child afraid of the dark? Yes No
What time does your child usually go to bed? _____
How many hours sleep does your child usually get? _____

Developmental History:

Birth:

Length of pregnancy:_____ Birth Weight _____lbs _____oz.

Child's condition at birth_____

Mother's condition at birth_____

Was this child born in a hospital? Yes No

Length of stay in Hospital: Mother: _____ Child: _____ days

Parent(s) adjustment to parenthood_____

Development:

At what age did this child first to the following?

Crawl_____ Walk alone_____ Speak First Words_____

Toilet train: Days:_____ Nights:_____

Did bed wetting occur after toilet training? Yes No

Did bed soiling occur after toilet training Yes No

Presenting Concerns

Why are you seeking help for this child?

_____
_____
_____
_____
_____

How long have these difficulties been occurring? _____

Has your child ever been hospitalized for mental health problems? Yes No
If yes, when and for how long_____

Are you aware of any substance use by your child? Yes No
If yes please fill out below:

Substance	1st Use	Last Use	Frequency	Amount

Is there a history of substance abuse problems in the family Yes No
If yes please describe: _____

_____
_____

Is there a history of mental illness in the family? This could include: Depression, anxiety, ADHD, Learning Problems, Schizophrenia, etc.

_____
_____
_____
_____

Has your child ever been arrested or convicted of a crime? Yes No

History of Abuse:

Has your child even been a part of or witness to physical violence? Yes No
Has your child even been a part of or witness to Emotional abuse? Yes No
Has your child even been a part of or witness to Sexual Abuse? Yes No

Intake worker use this space:

Family: Please describe how he/she gets along with each parent, brothers, and sisters, and other family members.

Peers: Please describe how your child gets along with other children/adolescents of both sexes

_____ _____

Parent's Signature Date