

Date: _____

File #: _____

IDENTIFIED CHILD/CHILDREN:

Name (First) (Last)		DOB (MO,DY,YR)	Gender ___male ___female
Address	PO Box:	City	Postal Code
Home Phone:		Cell Phone:	
School:	Grade:	Allergies:	Medication:

Name (First) (Last)		DOB (MO,DY,YR)	Gender ___male ___female
Address (if different from sibling)	PO Box:	City	Postal Code
Home Phone:		Cell Phone:	
School:	Grade:	Allergies:	Medication:

Marital Status of Parents: Single Married Common-Law Separated Divorced

Child is currently residing with: Mother Father Grandparents Foster Care Group Home Other _____

Child's Legal Guardian: _____

Are you currently involved in any legal process regarding custody and access: Yes No

Is there a legal custody agreement: Yes No

Custody Type _____ (A-Sole custody mother, B-Sole custody Father, C-Joint Custody, D-Interim, E-Other (explain))

If E-Other, Please Explain: _____

MOTHER:

Name: (First) (Last)	DOB: (MO,DY,YR)	Home Phone: Cell Phone:
Address (if different than child):		Work Phone: Email:

FATHER:

Name: (First) (Last)	DOB: (MO,DY,YR)	Home Phone: Cell Phone:
Address (if different than child):		Work Phone: Email:

STEP-PARENTS:

Step-Mother's Name:	DOB: (MO,DY, YR)
Step-Father's Name:	DOB: (MO,DY, YR)

SIBLINGS – currently living with child: (include relation – (i.e. brother/ half-brother))

Sib #	Name (First) (Last)	Relation (brother, half-brother, etc)	DOB: (MO,DY,YR)
1			
2			
3			
4			

1. Has your child or family received services from our agency in the past? Yes Date: _____ No

2. Have you ever accessed Mental Health Crisis Services at Bluewater Health for your child? Yes Date: _____ No

3. Who referred you to this clinic or how did you hear about this clinic? _____

4. List any other agencies or services involved: _____

5. Are you, your child, or anyone with you, at risk of harm to self or to others? Yes Who? _____ No

6. Is your child currently involved with the Youth Criminal Justice System? Yes No

7. What problem/concern would be most helpful to talk about today? _____

8. If 1 is the worst and 10 is the best, how are things in your life today?

Worst 1 2 3 4 5 6 7 8 9 10 Best

9. How does this problem affect:

a.) you? _____

b.) Your child/children? _____

10. How long has this problem been around?

1 - 3 months _____ in the last year _____ longer than a year _____

11. Imagine what will look different when the problem is not around. What will you see?

12. Tell us about a time when **you** solved a problem in a way that left **you** feeling proud.

13. What would someone who cares about **you** most appreciate about **you**?

14. What do you and/or others most appreciate about your **child/children**?

15. Is there anything you feel is important for us to know about your family's culture, ethnicity, religion, language, sexual orientation, mental or physical health, or other?

