SUBSTANCE ABUSE	RELATION TO CLIENT	MOTHER'S OR FATHER'S SIDE
☐ Alcoholism		☐ Mother's ☐ Father's
☐ Drug Use		☐ Mother's ☐ Father's
☐ Prescription Pill Abuse		☐ Mother's ☐ Father's
☐ Substance Use Treatment		☐ Mother's ☐ Father's
☐ Other		☐ Mother's ☐ Father's
LEGAL	**RELATION TO CLIENT**	**MOTHER'S OR FATHER'S SIDE**
☐ Convictions		☐ Mother's ☐ Father's
☐ Incarcerations		☐ Mother's ☐ Father's
☐ Other		☐ Mother's ☐ Father's

SECTION D: INDIVIDUAL AND CULTURAL CONSIDERATIONS

1. What ethnicity does the client identify with?

☐ American	☐ Hispanic/Latino	☐ Somali
☐ Asian	☐ Hmong	☐ Vietnamese
☐ East African	☐ Korean	☐ West African
☐ European	☐ Russian	☐ Not Disclosed
☐ Other (Please describe)		

2. What race does the client identify with?

☐ American Indian or Alaskan Native	☐ Black or African American	☐ White
☐ Asian	☐ Native Hawaiian or Pacific Islander	☐ Multiracial
☐ Not Disclosed	☐ Other (Please describe)	

3. Does the client identify with a faith or spiritual community? ☐ Yes ☐ No ☐ Unknown

If yes, what is your religious/spiritual belief/affiliation?

SECTION E: BASIC NEEDS AND SUPPORT SYSTEM

1. Is the client/family currently accessing any community resources for support? ☐ Yes ☐ No

COMMUNITY SERVICE	DESCRIPTION
☐ Advocacy Services (i.e., The Arc, PACER)	
☐ Case Management	
☐ County Services	
☐ Employment Services	
☐ Food Support (i.e., SNAP)	
☐ Housing Support (i.e., Section 8, GRH, MSA)	
☐ In-Home Health Support (i.e., Nurse)	
☐ Medical Assistance	
☐ PCA Care/Respite Care	
☐ Social Security	
☐ Social Worker	
☐ Transportation (i.e., Metro Mobility, medical transportation)	
☐ Waiver Services	
☐ WIC	
☐ Other	

4. Does client have any of the following significant medical conditions? ☐ Yes ☐ No ☐Unknown/Information not available
If yes, please select all that apply:

SIGNIFICANT MEDICAL CONDITIONS	PAST	CURRENT	DESCRIPTION
Asthma	☐	☐	
Seizures	☐	☐	
Food Restrictions	☐	☐	
Food Allergy	☐	☐	If Yes, is epinephrine injection (EpiPen) required? ☐ Yes ☐ No
Insect Sting Allergy	☐	☐	If Yes, is epinephrine injection (EpiPen) required? ☐ Yes ☐ No
Medication Allergies	☐	☐	If Yes, is epinephrine injection (EpiPen) required? ☐ Yes ☐ No
Environmental Allergies	☐	☐	
Diabetes	☐	☐	
G-tube	☐	☐	
Vision Impairment (i.e., blind)	☐	☐	
Hearing Impairment (i.e., deaf)	☐	☐	

5. Does client have any of the following? ☐ Yes ☐ No ☐Unknown/Information not available
If yes, please select all that apply:

OTHER MEDICAL CONDITIONS	PAST	CURRENT	DESCRIPTION
Surgeries	☐	☐	
Serious Accident(s)	☐	☐	
Head Trauma/Concussion	☐	☐	
Infectious Disease	☐	☐	
Vision Problems	☐	☐	
Appetite/Eating Concerns	☐	☐	
Sleep Concerns	☐	☐	
Frequent Headaches	☐	☐	
Frequent Stomachaches	☐	☐	
General Aches and Pains	☐	☐	
Sexualized Behavior Concerns	☐	☐	
Sexual Health Concerns (i.e., STD)	☐	☐	
Other Medical Concerns	☐	☐	

SECTION G: MEDICATIONS

1. List any current medications for both physical and mental health purposes:

MEDICATION NAME	REASON FOR PRESCRIPTION	DOSAGE	PRESCRIBED BY	MEDICATION HELPFUL? Y/N

2. List any past medications for mental health purposes:

MEDICATION NAME	REASON FOR PRESCRIPTION	DOSAGE	PRESCRIBED BY	WHY DISCONTINUED

SECTION H: MEDICAL AND MENTAL HEALTH SERVICES

1. Has the client participated in any evaluations or diagnostic assessments pertinent to the current concerns?

☐ Yes ☐ No ☐Unknown/Information not available

If yes, please select all that apply:

TYPE OF ASSESSMENT	DATE OF SERVICE	AGENCY	RESULTS OR DIAGNOSIS
☐ Diagnostic Assessment			
☐ Feeding Therapy Evaluation			
☐ Genetic Evaluation			
☐ Neurologic Evaluation			
☐ Neuropsychological Evaluations			
☐ Occupational Therapy Evaluation			
☐ Physical Therapy Evaluation			
☐ Psychiatric Evaluation			
☐ Psychological Evaluation			
☐ Speech Therapy Evaluation			
☐ Other			

2. Has the client participated in any services pertinent to the current concerns?
Please indicate date, agency, and results of evaluations/diagnosis given.

☐ Yes ☐ No ☐ Unknown/Information not available

If yes, please select all that apply:

TYPE OF SERVICE	LAST DATE OF SERVICE	AGENCY	FREQUENCY	RESULTS OR DIAGNOSIS
☐ ABA				
☐ ARMHS				
☐ Career Planning and Employment				
☐ Crisis Support				
☐ Day Treatment				
☐ Family Therapy				
☐ Feeding Therapy				
☐ Group Skills				
☐ Group Therapy				
☐ Individual Skills				
☐ Individual Therapy				

TYPE OF SERVICE	LAST DATE OF SERVICE	AGENCY	FREQUENCY	RESULTS OR DIAGNOSIS
☐ Occupational Therapy				
☐ Partial Hospitalization				
☐ Physical Therapy				
☐ Psychiatric Hospitalization				
☐ Psychiatry/Medication Management				
☐ Speech Therapy				
☐ Substance Use Treatment				
☐ Other:				
☐ Other:				
☐ Other:				

SECTION I: SERVICE PROVIDERS AND COORDINATION OF CARE

1. Primary Care Provider

Primary Care Provider Name	Clinic Name	Phone Number	Date of Last Visit

2. Dental Provider

Dental Provider Name	Clinic Name	Phone Number	Date of Last Visit

3. Is the client currently seeing, or has recently seen, any of the following providers?

☐ Yes ☐ No ☐ Unknown/Information not available

If yes, please select all that apply:

MEDICAL PROFESSIONAL	CLINIC/PROVIDER NAME	DATE OF LAST VISIT
☐ Allergist		
☐ Audiologist		
☐ Developmental Pediatrician		
☐ Feeding Clinic		
☐ Gastroenterologist		
☐ Geneticist		
☐ Mental Health (Non-Fraser)		
☐ Neurologist		
☐ Ophthalmologist		
☐ Pediatric Therapy (Non-Fraser)		
☐ Other:		
☐ Other:		
☐ Other:		

4. Preferred Emergency Care Provider

Emergency Care Name:	Phone Number:

5. Emergency Contact for the Client

Name:	Relationship:

Cell Phone:	Home Phone:	Work Phone:

SECTION J: STRESS AND TRAUMA

1. Has the client experienced or witnessed any of the following, resulting in distress?

EXPERIENCE	AGE OF OCCURRENCE/DESCRIPTION
☐ Adoption/International Adoption	
☐ Car Accident	
☐ Community Violence	
☐ Custody Conflict	
☐ Death	
☐ Divorce/Separation	
☐ Domestic Violence/Abuse	
☐ Family Conflicts	
☐ Family Medical/Mental Health Issues	
☐ Family Substance Abuse/Use	
☐ Fire	
☐ Frequent Moves	
☐ Immigration	
☐ Medical	
☐ Military Deployment	
☐ Natural Disaster	
☐ Out-of-Home Placement	
☐ Phyical Illness	
☐ Separation from Parent	
☐ Sexual Assault/Molestation	
☐ Unsafe Neighborhood/Community	
☐ Other:	

SECTION K: CLIENT LEGAL ISSUES

1. Has the client been involved in any legal issues?

☐ Yes ☐ No

If yes, please select all that apply:

LEGAL ISSUES	PAST	CURRENT	LEGAL ISSUES	PAST	CURRENT
Adult Protection	☐	☐	CPS Involvement	☐	☐
Alcohol and Drug-Related	☐	☐	Guardian ad litem	☐	☐
Awaiting Charge	☐	☐	Juvenile Detention	☐	☐
Convictions	☐	☐	On Parole	☐	☐
Court-Ordered Treatment	☐	☐	Other:	☐	☐

If Other, please explain:

SECTION L: SCHOOL INFORMATION

1. Is the client in school? ☐ Yes ☐ No
If No, check the highest level of schooling completed.

☐ ECSE	☐ Elementary School	☐ Transition Programming	☐ Associate Degree
☐ Pre-School	☐ Middle School	☐ Certificate/Trade Program	☐ Bachelor's or Higher
☐ Kindergarten	☐ High School/GED	☐ Some College	☐ Unknown

If Yes, fill in the following information.
a. Name of the current school:

b. Check the client's current grade in school:

☐ Childcare	☐ 3rd Grade	☐ 8th Grade	☐ Certificate/Trade Program
☐ Pre-School	☐ 4th Grade	☐ 9th Grade	☐ Associate's Degree
☐ Kindergarten	☐ 5th Grade	☐ 10th Grade	☐ Bachelor's or Higher
☐ 1st Grade	☐ 6th Grade	☐ 11th Grade	☐ Other
☐ 2nd Grade	☐ 7th Grade	☐ 12th Grade	

c. Has the client ever been on a 504 plan? ☐ Yes ☐ No ☐ Unknown
If Yes, describe:

d. Has the client ever been on an Individual Education Plan (IEP)/Individualized Family Services Plan (IFSP)?
☐ Yes ☐ No ☐ Unknown
If Yes, please select all that apply:

IEP/IFSP	PAST	CURRENT	IEP/IFSP	PAST	CURRENT
Autism Spectrum Disorder	☐	☐	Blind-Visually Impared	☐	☐
Deaf-Blind	☐	☐	Deaf, Hard of Hearing	☐	☐
Developmental/Cognitive Disability	☐	☐	Dev. Delay/Early Childhood Special Ed.	☐	☐
Emotional/Behavioral Disorder	☐	☐	Other Health Disability	☐	☐
Physical Impairment	☐	☐	Specific Learning Disability	☐	☐
Speech/Laguage Impairment	☐	☐	Traumatic Brain Injury	☐	☐
Unsure/Documentation Unavailable	☐	☐			

e. Has the client ever received any of the following services in school?If ☐ Yes ☐ No ☐ Unknown
Yes, please select all that apply:

SCHOOL SERVICES	PAST	CURRENT	COMMENTS
Academic Support (e.g., reading, math)	☐	☐	
Gifted and Talented/Enrichment	☐	☐	
Occupational Therapy	☐	☐	
Paraprofessional Support	☐	☐	
Physical Therapy	☐	☐	
Social Skills	☐	☐	
Speech Therapy	☐	☐	
Study Skills	☐	☐	
Other:	☐	☐	

f. Has the client had attendance or academic issues in school? ☐ Yes ☐ No ☐ Unknown
If Yes, please select all that apply

ATTENDANCE/ACADEMIC ISSUES	PAST	CURRENT	ATTENDANCE/ACADEMIC ISSUES	PAST	CURRENT
Problems with Grades	☐	☐	Suspensions/Expulsions	☐	☐
Problems with Attendance	☐	☐	Repeated Grades	☐	☐
Other:	☐	☐			

SECTION M: EMPLOYMENT INFORMATION

1. What is the client's employment status?

☐ Full-Time Employed	☐ Unemployed and would like Employment
☐ Part-Time Employed	☐ Not Employed (e.g., too young, not seeking employment, unable to work)

SECTION N: SAFETY/RISK ASSESSMENT

1. Does the cient demonstrate any safety/risk concerns? ☐ Yes ☐ No

SAFETY/RISK CONCERNS	PAST	CURRENT	SAFETY/RISK CONCERNS	PAST	CURRENT
Self-Harm Statements	☐	☐	Self-Harm Actions	☐	☐
Suicidal Ideation	☐	☐	Suicidal Attempt	☐	☐
Dangerous Behaviors to Others	☐	☐	Destruction of Property	☐	☐
Risk of Wandering/Running Away	☐	☐	Threatens to Harm Others	☐	☐

2. Is there a safety plan in place? ☐ Yes ☐ No

SECTION O: CLIENT/FAMILY STRENGTHS

Please describe client/family strengths:
What does the client do well and enjoy doing?
What do others and family enjoy about the client?
What does the family like doing together?