



Is the client adopted? No \_\_\_\_\_ Yes \_\_\_\_\_

Has the client ever been seen by a counselor or therapist No \_\_\_\_\_ Yes \_\_\_\_\_

Please list the names of counselors/therapists, city, and dates (month and year) client has seen him/her:

Name	City/State	Dates Seen
Name	City/State	Dates Seen
Name	City/State	Dates Seen
Name	City/State	Dates Seen
Name	City/State	Dates Seen

Has applicant ever been seen by a psychiatrist? No \_\_\_\_\_ Yes \_\_\_\_\_

Please list the names of psychiatrists, city, and dates (month and year) client has seen him/her:

Name	City/State	Dates Seen
Name	City/State	Dates Seen
Name	City/State	Dates Seen

Has client ever had a psychiatric inpatient hospital stay? No \_\_\_\_\_ Yes \_\_\_\_\_

Please list the names of hospitals, city, and dates of admission (month and year):

Hospital	City/State	Dates of Admission
Hospital	City/State	Dates of Admission
Hospital	City/State	Dates of Admission

Has client ever been placed out of the home? No \_\_\_\_\_ Yes \_\_\_\_\_

If so, where:

Facility	City/State	Dates of placement (month and year)	Reason for leaving
Facility	City/State	Dates of placement (month and year)	Reason for leaving
Facility	City/State	Dates of placement (month and year)	Reason for leaving
Facility	City/State	Dates of placement (month and year)	Reason for leaving

Is there anyone with whom client should not have contact? Please list.

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**Section 2: HEALTH**

Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Is client allergic to anything (food, medication, plants, animals)? \_\_\_\_\_ No \_\_\_\_\_ Yes

Please List: \_\_\_\_\_

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Does client suffer from any physical problems? \_\_\_\_\_ No \_\_\_\_\_ Yes

Please Explain: \_\_\_\_\_

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Please give the client's medication history.

Medication	Dose	Who prescribed it	____ Yes ____ No Is client still taking it?	Reason for stopping
Medication	Dose	Who prescribed it	____ Yes ____ No Is client still taking it?	Reason for stopping
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Medication	Dose	Who prescribed it	____ Yes ____ No Is client still taking it?	Reason for stopping
Medication	Dose	Who prescribed it	____ Yes ____ No Is client still taking it?	Reason for stopping
Medication	Dose	Who prescribed it	____ Yes ____ No Is client still taking it?	Reason for stopping
Medication	Dose	Who prescribed it	____ Yes ____ No Is client still taking it?	Reason for stopping

Name of client's physician: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

When was client last seen? \_\_\_\_\_

Does client need to be seen again for follow up? Please explain: \_\_\_\_\_

Name of client's dentist: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

When was client last seen? \_\_\_\_\_

Does client need to be seen again for follow up? Please explain: \_\_\_\_\_

Name of client's eye doctor: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

When was client last seen? \_\_\_\_\_

Does client need to be seen again for follow up? Please explain: \_\_\_\_\_

Does client wear glasses? Yes \_\_\_\_\_ No \_\_\_\_\_

Are client's immunizations up to date? Yes \_\_\_\_\_ No \_\_\_\_\_

Please attach immunization record or list below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 3: SCHOOL**

Last grade completed successfully: \_\_\_\_\_ Date: \_\_\_\_\_

Current Grade: \_\_\_\_\_

Last school attended: \_\_\_\_\_

\_\_\_\_\_  
City State

Is client currently in school?  Yes  No

Is client verified for Special Education?  No  Yes Verification: \_\_\_\_\_  
(Learning Disordered, Behaviorally Disordered, Handicap, Other Health Impaired, etc.)

**Section 4: EMPLOYMENT**

Has client ever been employed?  No  Yes

\_\_\_\_\_  
Where Dates (month and year)

\_\_\_\_\_  
Where Dates (month and year)

\_\_\_\_\_  
Where Dates (month and year)

Has client ever been fired from a job?  Yes  No

Reason(s): \_\_\_\_\_

**Section 5a: FAMILY** (If client is a foster child, please fill out this section for the biological father and mother and the section about the foster father and mother in section 5b)

**Father:**

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Biological  Adoptive

Address \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Please indicate marital status:

Married  Separated  Divorced  Widower  Single

Please list dates of:

Marriage \_\_\_\_\_ Separation \_\_\_\_\_ Divorce \_\_\_\_\_ Death of Spouse \_\_\_\_\_

If divorced or widower, has father remarried?  No  Yes

**Stepmother:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Mother:**

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Biological \_\_\_\_\_ Adoptive \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Please indicate marital status:

\_\_\_\_ Married    \_\_\_\_ Separated    \_\_\_\_ Divorced    \_\_\_\_ Widower    \_\_\_\_ Single

Please list dates of:

Marriage \_\_\_\_\_ Separation \_\_\_\_\_ Divorce \_\_\_\_\_ Death of Spouse \_\_\_\_\_

If divorced or widow, has mother remarried? \_\_\_\_ No    \_\_\_\_ Yes

**Stepfather:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Please list children in the family and their relationship to the client:

1. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_ Biological    \_\_\_\_ Step    \_\_\_\_ Half    Living in the home?    \_\_\_\_ No    \_\_\_\_ Yes
2. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_ Biological    \_\_\_\_ Step    \_\_\_\_ Half    Living in the home?    \_\_\_\_ No    \_\_\_\_ Yes
3. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_ Biological    \_\_\_\_ Step    \_\_\_\_ Half    Living in the home?    \_\_\_\_ No    \_\_\_\_ Yes

4. \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 \_\_\_\_\_ Biological \_\_\_\_\_ Step \_\_\_\_\_ Half \_\_\_\_\_ Living in the home? \_\_\_\_\_ No \_\_\_\_\_ Yes

5. \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 \_\_\_\_\_ Biological \_\_\_\_\_ Step \_\_\_\_\_ Half \_\_\_\_\_ Living in the home? \_\_\_\_\_ No \_\_\_\_\_ Yes

6. \_\_\_\_\_  
 Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 \_\_\_\_\_ Biological \_\_\_\_\_ Step \_\_\_\_\_ Half \_\_\_\_\_ Living in the home? \_\_\_\_\_ No \_\_\_\_\_ Yes

Others in household:

1. \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

2. \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

3. \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

4. \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

Has the family been involved with any type of therapy or counseling? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, please complete:

Name of Therapist/Counselor	City/State	Family Members Involved	Dates Seen (month and year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Section 5b: FOSTER FAMILY**

**Foster Father:**

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Foster Mother:**

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Children in the home:

1. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_\_ Biological child of Foster Parent(s) \_\_\_\_\_ Biological sibling of client \_\_\_\_\_ Foster child not related to family or client

2. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_\_ Biological child of Foster Parent(s) \_\_\_\_\_ Biological sibling of client \_\_\_\_\_ Foster child not related to family or client

3. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_\_ Biological child of Foster Parent(s) \_\_\_\_\_ Biological sibling of client \_\_\_\_\_ Foster child not related to family or client

4. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_\_ Biological child of Foster Parent(s) \_\_\_\_\_ Biological sibling of client \_\_\_\_\_ Foster child not related to family or client

5. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_\_ Biological child of Foster Parent(s) \_\_\_\_\_ Biological sibling of client \_\_\_\_\_ Foster child not related to family or client

6. \_\_\_\_\_  
Name Date of Birth  
\_\_\_\_\_ Biological child of Foster Parent(s) \_\_\_\_\_ Biological sibling of client \_\_\_\_\_ Foster child not related to family or client

Others in foster family's household:

1. \_\_\_\_\_  
Name Relationship Age

2. \_\_\_\_\_  
Name Relationship Age

3. \_\_\_\_\_  
Name Relationship Age

4. \_\_\_\_\_  
Name Relationship Age

