LIFESPAN OF MINNESOTA CLIENT INTAKE DATA/FACE SHEET

PLEASE COMPLETE ALL ITEMS THAT APPLY TO YOUR CHILD

Client Name _____ Birth Date _____

Last First Middle Sex: Male Female

Race _____

Address _____ Phone _____

_____ Age _____

Mother's Name _____ Home Phone _____

Address _____ Work Phone _____

_____ Cell Phone _____

Father's Name _____ Home Phone _____

Address _____ Work Phone _____

_____ Cell Phone _____

Foster Home _____ Home Phone _____

Address _____ Work Phone _____

_____ Cell Phone _____

Social Worker/Probation Officer _____ Phone _____

County _____

Emergency Contact _____ Home Phone _____

Relationship _____ Cell Phone _____

Outpatient Therapist/Agency _____ Phone _____

Psychiatrist _____ Phone _____

School _____ Grade _____

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Client Name: **Birth Date:**

School Counselor _____ Phone _____

FOR OFFICE USE ONLY

Former Client	Yes No	Chart #	
Funding			
Program			
Intake Date		Start Date	
Discharge Date		Therapist	

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Client Name: **Birth Date:**

Person Completing Form | Relationship to Client | Date

FAMILY OF ORIGIN

Biological Father's Name _____ Age _____ Occupation _____

	Yes	No
Living with the child?		
Have legal custody?		
Have regular contact?		

Biological Mother's Name _____ Age _____ Occupation _____

	Yes	No
Living with the child?		
Have legal custody?		
Have regular contact?		

Nature of Relationship _____ Dates _____

ADDITIONAL MARRIAGES/RELATIONSHIPS

List any additional marriages or live-in relationships with which the child has had contact:

Father:

Name _____ Age _____ From _____ To _____
Name _____ Age _____ From _____ To _____
Name _____ Age _____ From _____ To _____

Mother:

Name _____ Age _____ From _____ To _____
Name _____ Age _____ From _____ To _____
Name _____ Age _____ From _____ To _____

CHILDREN

List all children, including those by previous and additional relationships as well as any deceased:

Name	Age	Male	Female	Relationship to Your Child	Living With Your Child Yes	No

Client Name: **Birth Date:**

OTHERS

List other persons involved in your child's life or who your child sees as significant:

Name	Age	Male	Female	Relationship to Your Child	Living With Your Child Yes	No

Please check all of the following that apply to your child currently:

ATTENTION

- ___ Spends a lot of time in fantasy
- ___ Poor attention span
- ___ Doesn't listen
- ___ Easily distracted
- ___ Forgetful (poor memory)
- ___ Loss of memory
- ___ Difficulty following instructions
- ___ Has difficulty concentrating
- ___ Difficulty solving problems
- ___ Doesn't finish tasks
- ___ Problems organizing self
- ___ Avoids tasks requiring concentration
- ___ Does a lot of daydreaming
- ___ Difficulty distinguishing left from right
- ___ Disorientation (confusion)

ACTIONS

- ___ Makes careless mistakes
- ___ Fidgets or squirms
- ___ Talks all the time
- ___ Interrupts
- ___ Loses needed items
- ___ Leaves seat when required to sit
- ___ Runs, climbs excessively or is restless
- ___ Has problems waiting for a turn
- ___ Is on the go, seems driven
- ___ Poor coordination (clumsy)

SPEECH

- ___ Stuttering
- ___ No Speech
- ___ Compulsive speech (can't stop)
- ___ Frequent throat clearing
- ___ Poor speech articulation
- ___ Repeating words or sentences
- ___ Repeating (echoing) what others say
- ___ Habits like grunts, snorts or barks

SLEEP

- ___ Increased amount of sleep
- ___ Awakening often
- ___ Decreased amount of sleep
- ___ Nightmares

Client Name: **Birth Date:**

- ____ Awakening early
- ____ Periods of no sleep
- ____ Refuses to go to bed
- ____ Sleep walks
- ____ Talks in his/her sleep
- ____ Inability to fall asleep
- ____ Periods of low/no energy
- ____ Wets the bed
- ____ Tosses and turns all night
- ____ Yells or cries out during sleep

WEIGHT/APPETITE

- ____ Decrease in appetite
- ____ Maintaining no appetite
- ____ Increase in weight
- ____ Obsessive of body image
- ____ Unrealistic view of self as fat
- ____ Sensitive about discussing food or weight
- ____ Increase in appetite
- ____ Concern about weight
- ____ Decrease in weight
- ____ Episodes of crash dieting
- ____ Ever made yourself throw up

THOUGHTS

- ____ Thoughts seem to race
- ____ Problems recalling things
- ____ Inability to stay focused
- ____ Recurring thoughts
- ____ Bizarre or unusual behaviors
- ____ Ignores the environment
- ____ Spaces off at times
- ____ Hears things others don't
- ____ Slowed thinking processes
- ____ Random/irrelevant thoughts
- ____ Behavior inconsistent with situation
- ____ Often thinks about violence or death
- ____ Hallucinations
- ____ Off in "own little world"
- ____ Rage outbursts
- ____ Sees things others don't

SELF/RELATIONSHIPS

- ____ Inability to make friends
- ____ Problems with parents
- ____ Problems with siblings
- ____ Extends friendships to strangers
- ____ Inability to keep friends
- ____ Problems with other children
- ____ Unable to react to others
- ____ Problems with other adults
- ____ No boundary limits with friends
- ____ Prefers older or younger friends
- ____ Sees self as a victim
- ____ Explode at others

SEXUAL

- ____ Has been sexually abused
- ____ Preoccupied with sexual themes
- ____ Is sexually aggressive to others
- ____ Is uncomfortable with own gender
- ____ Feels like opposite sex
- ____ Demonstrates inappropriate sexual knowledge for age

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Client Name: **Birth Date:**

- Engages in sexual behavior
- Play seems sexual
- Problems with flashbacks

EMOTIONS

Hopeless	Angry	Sad	Hurt	Overwhelmed
Unloved	Tearful	Guilty	Calm	Embarrassed
Lonely	Happy	Excited	Numb	Resentful
Confused	Lustful	Secure	Silly	Compassionate
Ashamed	Insecure	Jealous	Bored	Frustrated
Confident	Disgusted	Loving	Loved	Remorseful

DEPRESSED MOOD AND ACTIONS

Frequent crying spells	Hopeless feelings	Negative about most things
Has inflicted self injuries	Guilty feelings	Frequently is sad
Isolates self	Loss of interest in activities	Stubborn and argumentative
Wishes to be dead	Gives away possessions	Unable to enjoy things
Low self esteem	Has quit trying to do things	

FEARS/WORRIES

- Intensive fear or phobias
- Avoids being alone
- Nail biting
- Nervous tics or habits
- Nightmares about separation
- Fear of new places or situations
- Worries about parent(s) leaving
- Soiling of clothes or bed sheets
- Must repeat same behavior
- Won't let go of a thought
- Perfectionist, must be perfect
- Worries something terrible will happen to self or important adults
- Refuses to go somewhere because of fear of separation
- Frequent fear to go to sleep without someone close by
- Physical complaints about the time of separation
- Is concerned beyond reason about the outcome of some event

BEHAVIORS

- Often loses temper
- Argues with adults
- Defies adult's requests
- Deliberately annoys people
- Blames others for own mistakes
- Is very touchy about things
- Gets easily annoyed at others
- Is angry and resentful often
- Usually is spiteful and vindictive
- Is physically cruel to animals
- Often bullies or intimidates others
- Initiates physical fights
- Has used a weapon to harm others
- Steals by confronting victims
- Has broken into other's property
- Stays out at night without permission
- Lies to obtain goods or avoid obligations
- Deliberately has set fires
- Has forced someone into sexual activity
- Truant from school

Client Name: **Birth Date:**

____ Is physically cruel to people	____ Has run away from home for at least over night
____ Has stolen nontrivial items	____ Suicidal thoughts or attempt
____ Self-destructive behaviors	____ Too much time spent with TV, videos, games or computers
____ Immature childish behaviors	____ Shoplifts
____ Destroys other's property	

SCHOOL

School your Child is presently attending: _____

Primary Teacher: _____ Phone #: _____

Highest Grade Completed: _____ Grade Average: _____

Please answer the following questions about school:	Yes	No
Is it difficult for your child?	____	____
Does your child enjoy it?	____	____
Is it easy for your child to make friends?	____	____
Does your child have a learning disability?	____	____
Has your child been tested for Talented and Gifted Program?	____	____
Does your child have any behavioral problems?	____	____
Are there any attendance problems with your child?	____	____
Does your child have problems with peers?	____	____
Are there problems with teachers for your child?	____	____
Does your child attend special education classes?	____	____
Has your child had to repeat any grades?	____	____
Were there any difficulties for your child adjusting to Junior High/Middle School?	____	____
Were there any difficulties for your child adjusting to High School?	____	____

List anything that you feel needs to be explained from the above questions:

_____

_____

_____

List any activities in which your child is involved:

_____

_____

Client Name: **Birth Date:**

Does your child have an IEP (Individual Education Plan) Yes No

Date the IEP was created _____

Type Learning Disabilities Emotional or Behavioral Disorder Both