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 _____

School Counselor _____ Phone _____

FOR OFFICE USE ONLY

Former Client ☐ Yes ☐ No Chart # _____
Funding _____
Program _____

Intake Date _____ Start Date _____
Discharge Date _____ Therapist _____

LIFESPAN OF MINNESOTA PARENT AND CHILD QUESTIONNAIRE
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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

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

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Client Name: _____ **Birth Date:** _____

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
_____ Awakening early
_____ Periods of no sleep
_____ Refuses to go to bed
_____ Sleep walks
_____ Talks in his/her sleep
_____ Decreased amount of sleep
_____ Nightmares
_____ 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

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Client Name: _____ **Birth Date:** _____

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
_____ Engages in sexual behavior
_____ Problems with flashbacks
_____ Is uncomfortable with own gender
_____ Feels like opposite sex
_____ Demonstrates inappropriate sexual knowledge for age
_____ Play seems sexual

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
_____ Has inflicted self injuries
_____ Isolates self
_____ Wishes to be dead
_____ Low self esteem
_____ Hopeless feelings
_____ Guilty feelings
_____ Loss of interest in activities
_____ Gives away possessions
_____ Has quit trying to do things
_____ Negative about most things
_____ Frequently is sad
_____ Stubborn and argumentative
_____ Unable to enjoy 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
_____ Is physically cruel to people
_____ Has stolen nontrivial items
_____ Self-destructive behaviors
_____ Immature childish behaviors
_____ Destroys other's property
____ 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
____ Has run away from home for at least over night
____ Suicidal thoughts or attempt
____ Too much time spent with TV, videos, games or computers
____ Shoplifts

Client Name: _____ **Birth Date:** _____

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:

_____

_____

_____

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

Date the IEP was created _____

Type ☐ Learning Disabilities ☐ Emotional or Behavioral Disorder ☐ Both