



CHILD/ADOLESCENT INTAKE

General Instructions

Please fill out these forms as fully and openly as possible. This information is helpful to ensure an accurate assessment, which will assist us in making appropriate diagnostic decisions and recommendations. Please feel free to attach any additional information that you think might help us better understand the child/adolescent (i.e., past psychological reports, etc.). We appreciate your cooperation and willingness to complete these forms prior to the initial appointment.

When completing these forms, please consider the following:

- Please read the questions carefully and answer them in full. Please ask for clarification if you do not understand an item.
- Write as legibly as possible.
- The child/adolescent's parent/guardian and/or the child/adolescent should complete the forms.
- Please understand that this information is for evaluation, intervention, and recommendation purposes. The information you provide will be part of the evaluation. If there are specific details that you are hesitant in sharing, please bring these issues to our attention during your appointment.

Thank you in advance for completing these forms.

Child, Youth & Family Mental Wellness

What are the child/adolescent's strengths (personality traits, skills, etc.)? What strengths does client/adolescent have that will help them reach their goals?

What does the child/adolescent do to cope with their problems/difficulties?

- ☐ EXERCISE ☐ PLAYS VIDEO/COMP. GAMES ☐ TIME ALONE
☐ LISTEN/PLAY MUSIC ☐ READ ☐ WATCH TV/MOVIES ☐ OTHER: _____
☐ MAKE ART ☐ TALK TO FRIEND/FAMILY ☐ WRITING
☐ PLAY WITH A PET ☐ TAKE BATH/SHOWER ☐ UNKNOWN

Child's Mental Health Treatment History

Has the child/adolescent ever been diagnosed with a mental health, emotional, or psychological condition?

☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (diagnosis given, when, by whom):

Has the child/adolescent ever had any emergency room visits for emotional or behavioral problems?

☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (reason, date, outcome, and name of hospital):

Past or current mental health treatment? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE COMPLETE TABLE BELOW.

TYPE OF TREATMENT	DATE(S)	PROVIDER/CLINIC NAME	DIAGNOSES/REASON
☐ OUTPATIENT MENTAL HEALTH TREATMENT			
☐ INPATIENT MENTAL HEALTH HOSPITALIZATION			
☐ OTHER (i.e., CLIP, residential): _____			

COMMENT ON CHILD/ADOLESCENT'S MENTAL HEALTH HISTORY (describe further if needed):

Child's Substance Use Disorder & Problem Gambling Treatment History

Past or current substance use disorder treatment? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE COMPLETE TABLE BELOW.

TYPE OF TREATMENT	DATE(S)	PROVIDER/CLINIC NAME	DIAGNOSES/REASON
☐ OUTPATIENT SUBSTANCE USE DISORDER TREATMENT			
☐ INPATIENT TREATMENT FOR DRUGS/ALCOHOL			
☐ OTHER (i.e., detox, relapse prevention): _____			

Past or current problem gambling treatment? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (dates, provider/clinic name, diagnoses/reason):

COMMENT ON CHILD/ADOLESCENT'S SUBSTANCE USE DISORDER OR PROBLEM GAMBLING TREATMENT HISTORY (describe further if needed):

CLIENT NAME/DOB/MRN
(or affix label)

Child's Medical History

MEDICAL ISSUES/CONCERNS & TREATMENT			
Primary Care Provider Name (i.e., pediatrician, nurse practitioner):			
Other Medical Providers Name(s):			
If it has been more than one year since the child/adolescent's last physical exam, we recommend scheduling an appointment with their doctor or health care provider. We also recommend routine vision and dental appointments whenever possible. Please tell your clinician if you need assistance in this area.			
How would you describe the child/adolescent's overall physical health? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR			
Does the child/adolescent have any allergies? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, WHAT ARE THEY ALLERGIC TO? _____ WHAT IS THE REACTION? _____			
Current significant medical concerns or problems? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE EXPLAIN: _____			
Does the child/adolescent have a history of any of the following medical conditions/injuries or chronic health problems? (check all that apply):			
☐ ASTHMA	☐ HEARING PROBLEMS	☐ LOSS OF CONSCIOUSNESS (after an accident)	☐ NO
☐ BLACKOUTS	☐ HEART CONDITION	☐ SEIZURES (convulsions)	☐ UNKNOWN
☐ DIABETES	☐ HIGH FEVERS (over 103° F.)	☐ VISION PROBLEMS	☐ OTHER _____
☐ HEAD INJURY	☐ POISONING OR OVERDOSE		
Has the child/adolescent ever had a surgery or procedure? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE EXPLAIN: _____			
Any concerns or difficulties with the child/adolescent's hygiene? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE EXPLAIN: _____			
Is child/adolescent currently receiving treatment for any medical conditions? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE COMPLETE TABLE BELOW.			
MEDICAL CONDITION	DATE(S)	PROVIDER/CLINIC NAME	TREATMENT/RESPONSES
COMMENT ON CHILD/ADOLESCENT'S MEDICAL HISTORY (describe further if needed):			

MEDICATIONS				
Any currently prescribed and/or over-the-counter medications/supplements? ☐ YES ☐ NO ☐ UNKNOWN				
IF YES, PLEASE COMPLETE TABLE BELOW.				
MEDICATION NAME	DOSE	PRESCRIBER (IF APPLICABLE)	REASON	SIDE EFFECTS
Is the child/adolescent taking the medications as prescribed?				
☐ YES ☐ NO ☐ UNKNOWN ☐ N/A				
IF NO, PLEASE EXPLAIN: _____				
Has the child/adolescent ever been prescribed psychiatric medication (not listed in the table above)? ☐ YES ☐ NO ☐ UNKNOWN				
IF YES, PLEASE EXPLAIN (medication names, doses, etc.):				

CLIENT NAME/DOB/MRN
(or affix label)

Family Psychiatric/Medical History

Please fill out the family history to the best of your ability. Check all that apply to biological family. Please list any relatives on either side of the family who have had the following:

OTHER FAMILY CONCERNS	RELATIONSHIP TO CHILD/ADOLESCENT	MOTHER'S SIDE	FATHER'S SIDE
MEDICAL			
Diabetes		☐	☐
Heart disease		☐	☐
Heart failure		☐	☐
"Immune" disease		☐	☐
Thyroid disease		☐	☐
Other neurological problems: _____		☐	☐
Other health problems: _____		☐	☐
PSYCHIATRIC/BEHAVIORAL HEALTH			
ADD/ADHD		☐	☐
Alcohol abuse/drinking problems		☐	☐
Anxiety		☐	☐
Bipolar disorder		☐	☐
Depression		☐	☐
Intellectual disability		☐	☐
Learning problems		☐	☐
Mania		☐	☐
OCD		☐	☐
Personality disorder		☐	☐
Psychiatric hospitalizations		☐	☐
Schizophrenia/other psychosis		☐	☐
Substance abuse/drug problems		☐	☐
Suicide attempts/killed themselves		☐	☐
Tics or movement disorders		☐	☐
COMMENT ON FAMILY PSYCHIATRIC/MEDICAL HISTORY:			

Child's Developmental History

PREGNANCY			
How was the mother's overall health during the pregnancy with this child/adolescent? ☐ GOOD ☐ FAIR ☐ POOR ☐ UNKNOWN			
During pregnancy, did the biological mother have any of the following? (select all that apply)			
☐ BLEEDING	☐ INFECTION	☐ NO PRENATAL CARE	☐ OTHER PREGNANCY
☐ GOT INJURED/HURT	☐ TOXEMIA	☐ UNKNOWN	PROBLEMS/ILLNESS: _____
During pregnancy, did the mother use any of the following? (select all that apply)			
☐ ALCOHOL	☐ STREET DRUGS	☐ UNKNOWN	
☐ TOBACCO	☐ PRESCRIPTION MEDICATIONS		
IF YES, PLEASE EXPLAIN (describe amount and frequency, participation in treatment, birth defects or malformations due to drug/alcohol use among siblings):			

BIRTH/EARLY INFANCY			
Was this child/adolescent born before he/she was due (premature)? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, LENGTH OF PREGNANCY: _____ MONTHS			
Was delivery? ☐ NORMAL ☐ BREACH ☐ CAESARIAN ☐ FORCEPS/VACUUM ASSISTED ☐ INDUCED ☐ UNKNOWN			
Did the baby have any of the following during/after delivery? (select all that apply)			
☐ BORN WITH CORD AROUND NECK	☐ HAD SEIZURES (FITS, CONVULSIONS)	☐ WAS A TWIN OR TRIPLET	
☐ INJURED DURING BIRTH	☐ TURNED BLUE (CYANOSIS)	☐ CAN'T REMEMBER	
☐ HAD TROUBLE BREATHING	☐ NEEDED OXYGEN	☐ UNKNOWN	
☐ HAD AN INFECTION	☐ SPENT TIME IN NICU	☐ OTHER ISSUES/COMPLICATIONS: _____	
	☐ WAS VERY JITTERY		
Did the mother experience post-partum depression? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE EXPLAIN: _____			

CLIENT NAME/DOB/MRN
(or affix label)

DEVELOPMENTAL MILESTONES**Have you or anyone else ever had concerns about this child/adolescent's development (i.e., walking, talking, learning)?**☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN: _____

Are there any developmental milestones that the child/adolescent did late or is still having trouble with?

☐ SITTING	☐ SPOKE FIRST WORDS	☐ BOWEL TRAINED	☐ PLAYING COOPERATIVELY
☐ ROLLING OVER	☐ SAID PHRASES	☐ SLEEPING ALONE	☐ NO
☐ STANDING WITHOUT SUPPORT	☐ SAID SENTENCES	☐ DRESSING SELF	☐ UNKNOWN
☐ WALKING WITHOUT ASSISTANCE	☐ BLADDER TRAINED – DAY	☐ ENGAGING PEERS	☐ OTHER: _____
	☐ BLADDER TRAINED - NIGHT	☐ TOLERATING SEPARATION	

COMMENT ON DEVELOPMENTAL HISTORY/CONCERNS (describe further if needed): _____

Child's School Functioning/Education**Current school name (where enrolled):** _____**Current grade level OR indicate highest grade completed (if not currently enrolled in school):**

☐ NEVER ATTENDED OR BELOW PRESCHOOL	☐ KINDERGARTEN	☐ SOME COLLEGE
☐ NURSERY SCHOOL, PRE-SCHOOL, HEAD START	☐ GRADE: _____	☐ UNKNOWN
	☐ HIGH SCHOOL DIPLOMA OR GED	

Current education status (including home schooling):

☐ FULL-TIME (1st-12th grade: 20+ hours per week; kindergarten and >12 grade: 12+ hours per week).	☐ NOT IN EDUCATIONAL OR TRAINING ACTIVITIES
☐ PART-TIME (1st-12th grade: less than 20 hours per week; kindergarten and >12 grade: less than 12 hours per week).	☐ UNKNOWN

Concerns in any of the following areas (check all that apply):

☐ ATTENDANCE	☐ GRADES	☐ OTHER ACADEMIC/SCHOOL CONCERNS: _____
☐ DISCIPLINARY OR BEHAVIORAL ISSUES	☐ UNKNOWN	
	☐ N/A	

Has the child/adolescent ever skipped a grade or been held back? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN: _____

Has the child/adolescent ever been suspended or expelled? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, PLEASE EXPLAIN (date[s] and reason[s], # of times in current school year): _____

Does the child/adolescent have any diagnosed learning disabilities? (check all that apply)

☐ AUTISM SPECTRUM DISORDER	☐ SENSORY INTEGRATION DISORDER	☐ OTHER HEALTH IMPAIRED: _____
☐ DEVELOPMENTAL/COGNITIVE DELAY	☐ SPEECH OR LANGUAGE IMPAIRED	
☐ EMOTIONAL/BEHAVIORAL DISORDER	☐ TRAUMATIC BRAIN INJURY	☐ NO - child has been tested determined not to need services
☐ HEARING IMPAIRED	☐ VISUALLY IMPAIRED	☐ NO – never tested
☐ PHYSICALLY IMPAIRED	☐ UNKNOWN	

IF YES, PLEASE EXPLAIN: _____

Does the child/adolescent receive special education services? (check all that apply)

☐ INDIVIDUALIZED EDUCATION PLAN (IEP)	☐ OTHER: _____
☐ 504 PLAN	☐ NO
☐ SPECIAL EDUCATION ACCOMMODATIONS	☐ N/A

Please provide a copy of the IEP or 504 Plan (if applicable) if you haven't already done so.

COMMENTS ON CHILD/ADOLESCENT'S EDUCATION/SCHOOL FUNCTIONING (describe further if needed): _____

CLIENT NAME/DOB/MRN
(or affix label)

Child's Living Situation & Family Relationships

LIVING SITUATION			
Current type of housing (check all that apply):			
☐ APARTMENT	☐ GROUP HOME	☐ HOUSE	☐ OTHER: _____
☐ CONDOMINIUM	☐ HOMELESS	☐ MOBILE HOME	_____
☐ CORRECTIONAL FACILITY	☐ HOTEL/MOTEL	☐ SHELTER	_____
Was the child/adolescent adopted or guardianshiped? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, AT WHAT AGE? _____			
Current custody and parenting plan:			
☐ LIVES WITH BOTH PARENTS (biological or adoptive) IN SAME HOUSEHOLD		☐ SHARED CUSTODY – parents in different households	
☐ SINGLE PARENT		☐ FOSTER CARE/YOUTH-IN-NEED-OF-CARE (YINC)	
		☐ OTHER (describe): _____	
Please provide a copy of the parenting plan (if applicable) if you haven't already done so.			
Was there ever a time when the child/adolescent could not live at home and someone else had to look after them?			
☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE EXPLAIN: _____			
Is there a history of Child Protective Services (CPS) and/or Indian Child Welfare/beda?chelh involvement with family?			
☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE EXPLAIN (provide placement history, etc.): _____			
Any family concerns or stressors?			
☐ FAMILY MEMBER LEGAL ISSUES	☐ FAMILY MEMBER INCARCERATION	☐ TRANSPORTATION NEEDS	☐ UNKNOWN
☐ FINANCIAL CONCERNS	☐ LACK OF FOOD	☐ VIOLENCE/SAFETY	☐ OTHER FAMILY STRESSORS: _____
☐ FAMILY MEMBER DISABILITY	☐ HOUSING/UTILITIES	☐ NONE	_____
Does the child/adolescent have immediate access to firearms at home, relative's home, and/or friend's home?			
☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE EXPLAIN: _____			
Brief family history and major life events (important events, moves, accomplishments, losses/deaths, etc.):			
What else do you think is important for us to understand about the housing/living situation?			

CLIENT NAME/DOB/MRN
(or affix label)

RELATIONSHIPS BETWEEN CHILD (CLIENT) AND PARENT/GUARDIAN - Please list below the names, ages, relationships, and other relevant information regarding the child/adolescent's parents/guardians/caregivers (i.e., biological parents, adoptive parents, step-parents, placement parents, etc.). Please indicate below the best descriptions of parent-child relationships.

RELATIONSHIP TO CHILD/ADOLESCENT	NAME	AGE	OCCUPATION	LIVING IN THE SAME HOME (AS CHILD)	QUALITY OF RELATIONSHIP	PARENT-CHILD CONFLICT
Biological Father				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
Biological Mother				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
				☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE

Cooperation between parents regarding child-rearing?

☐ ALWAYS ☐ USUALLY ☐ INCONSISTENTLY ☐ RARELY ☐ N/A

COMMENT ON PARENT-CHILD RELATIONSHIPS (describe further if needed):

RELATIONSHIPS(S) BETWEEN CHILD (CLIENT) AND SIBLING(S) - Please list the names and ages regarding the child/adolescent's siblings (i.e., biological siblings, step-siblings, placement siblings, etc.).

RELATIONSHIP TO CHILD/ADOLESCENT	NAME	AGE	LIVING IN THE SAME HOME (AS CHILD)	QUALITY OF RELATIONSHIP	SIBLING-CHILD CONFLICT
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ YES ☐ NO	☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE

COMMENT ON SIBLING-CHILD RELATIONSHIPS (describe further if needed):

CLIENT NAME/DOB/MRN
(or affix label)

RELATIONSHIP(S) BETWEEN CHILD (CLIENT) AND OTHER PEOPLE LIVING IN THE HOME - Please list below the names and ages regarding other individuals living in the same home as the child/adolescent (who weren't already listed in the tables above).				
RELATIONSHIP TO CHILD/ADOLESCENT	NAME	AGE	QUALITY OF RELATIONSHIP	INDIVIDUAL-CHILD CONFLICT
			☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE
			☐ GOOD ☐ FAIR ☐ POOR	☐ NONE/MILD ☐ MODERATE ☐ SEVERE

COMMENT ON OTHER RELATIONSHIPS (describe further if needed):

Child's Religious/Spiritual Involvement and Cultural Background

Does child/adolescent practice any particular cultural traditions, spirituality, and/or religion? ☐ YES ☐ NO ☐ UNKNOWN
 IF YES, PLEASE EXPLAIN: _____

Are there any personal, religious, spiritual or cultural practices or beliefs that you want taken into account when treatment planning? ☐ YES ☐ NO ☐ UNKNOWN
 IF YES, PLEASE EXPLAIN: _____

COMMENT ON RELIGIOUS/SPIRITUAL INVOLVEMENT AND CULTURE (describe further if needed):

Child's Gender Identity

Has the child given any signs that they identify with a gender that is not consistent with their biological sex?
☐ YES ☐ NO ☐ UNKNOWN
 IF YES, PLEASE EXPLAIN: _____

COMMENT ON GENDER IDENTITY (describe further if needed):

Child's Sexual Development (For Adolescents aged 12 to 18 years)

Have you ever had concerns about the adolescent's sexual development or behaviors? ☐ YES ☐ NO ☐ UNKNOWN
 IF YES, PLEASE EXPLAIN: _____

How does the adolescent identify their sexual orientation?
☐ STRAIGHT ☐ GAY ☐ LESBIAN OR GAY ☐ UNKNOWN
☐ BISEXUAL ☐ LESBIAN ☐ CHOOSE NOT TO DISCLOSE ☐ OTHER: _____

Is the adolescent sexually active?
☐ YES ☐ NOT CURRENTLY ☐ NEVER ☐ UNKNOWN

Which birth-control/protection does the adolescent use? _____

COMMENT ON SEXUAL DEVELOPMENT (describe further if needed):

CLIENT NAME/DOB/MRN
(or affix label)

Child's Employment History

Child/adolescent's current employment status (check all that apply):			
☐ FULL TIME	☐ STUDENT – FULL TIME	☐ DISABLED	☐ NOT EMPLOYED
☐ PART TIME	☐ STUDENT – PART TIME	☐ SELF-EMPLOYED: _____	☐ UNKNOWN
Any employment history for the child/adolescent? ☐ YES ☐ NO ☐ UNKNOWN			
IF YES, PLEASE EXPLAIN: _____			
COMMENT ON EMPLOYMENT HISTORY (describe further if needed): 			

Child's Legal Involvement/History

Is the child/adolescent under department of corrections (JRA/DOC) supervision? ☐ YES ☐ NO ☐ UNKNOWN
Is the child/adolescent under criminal court ordered mental health or substance use disorder treatment? ☐ YES ☐ NO ☐ UNKNOWN
If you answered <u>yes</u> to either of the above questions, is there a court order exempting child/adolescent from reporting requirements? ☐ NO ☐ YES - <i>If so, a copy of the court order must be included in the record – please provide a copy.</i>
Does the child/adolescent have a history of legal involvement? (check all that apply)
☐ LEGAL CHARGES (i.e., traffic, civil, DWI/DUI, criminal, etc.) ☐ SERVED ANY TIME IN DETENTION ☐ LEGAL CONVICTIONS (i.e., traffic, DWI/DUI, etc.) ☐ NO LEGAL INVOLVEMENT/NONE ☐ LESS RESTRICTIVE ALTERNATIVE (LRA) OR CONDITIONAL RELEASE (CR) ☐ UNKNOWN ☐ OTHER: _____
COMMENT ON LEGAL INVOLVEMENT (describe further if needed):

Child's Social, Community, Recreational Activities and Supports

Who does and/or can the child/adolescent count on for support (i.e., important friends, extended family members, neighbors, coaches, school staff, church/faith community, etc.)? _____
Does the child/adolescent utilize any community resources/services?
☐ 12-STEP PROGRAM(S) (i.e., Alateen, etc.) ☐ FAMILY HAVEN ☐ SCHOOL-BASED SERVICES ☐ OTHER SOCIAL SERVICES/RESOURCES: _____ ☐ BOYS & GIRLS CLUB ☐ MENTORING ☐ YOUTH SERVICES _____ ☐ CHILD ADVOCACY CENTER (CAC) ☐ TUTORING ☐ NO _____ ☐ SELF-HELP GROUPS ☐ UNKNOWN _____
Does the child/adolescent have any hobbies, or is involved in any activities? (check all that apply)
☐ AFTER-SCHOOL ACTIVITIES ☐ PERFORMING ARTS ☐ NO ☐ OTHER HOBBIES/ACTIVITIES: _____ ☐ CLUBS ☐ SPORTS ☐ UNKNOWN _____ ☐ CHURCH/RELIGIOUS SERVICE ☐ VOLUNTEERING _____
COMMENT ON ACTIVITIES AND SUPPORTS (describe further if needed):

Additional Information

What else would you like for us to be aware of? CLIENT NAME/DOB/MRN (or affix label)
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