



Kansas Children's Service League

Clinical Services Demographic Form

Each Question Must be Completed to Obtain Services

CLIENT INFORMATION

Date: _____ Social Security #: _____ Date of Birth: _____

Client Name: _____
First Middle Last

Age: _____ Phone Number: _____ Email: _____

Home Address: _____
Street Apt#

City: State: Zip Code: County:

Sex: Male Female Ethnicity: Hispanic or Latino Non-Hispanic

Race: White Black American Indian and Alaska Native Asian Hawaiian and other Pacific Islander Two or more races Other
Income Level: Less than \$10,000 \$10,000- \$14,999 \$15,000-\$24,999 \$25,000-\$34,999 \$35,000-\$49,999 \$50,000-\$74,999 \$75,000+

Number in Household: _____

How did you hear about KCSL? _____

Are therapy services court ordered? If so please explain: _____



Kansas Children's Service League

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber Name: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____ ID#: _____

Secondary Insurance: _____ Subscriber Name: _____

Date of Birth _____ Social Security Number: _____

Employer: _____ ID#: _____

I attest that the information provided is true and accurate to the best of my knowledge. I understand that it is my responsibility to notify the Kansas Children's Service League of any changes in patient information and that I am responsible for any charges that might incur resulting from failure to do so.

Client / Responsible Party Signature	Date
--------------------------------------	------



Kansas Children's Service League

History & Physical

Please fill out the following information. If you have any questions, please ask the receptionist. Thank you.

History of presenting Illness/Concern:

Please check any of the following problems the client is experiencing:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Fire setting | <input type="checkbox"/> Running away | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sex problems | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sexual/Physical/Emotional Abuse | <input type="checkbox"/> Toilet problems |
| <input type="checkbox"/> Cruelty | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Under-activity |
| <input type="checkbox"/> Depression/Sadness | <input type="checkbox"/> Lying | <input type="checkbox"/> Staring Spells | |
| <input type="checkbox"/> Destructiveness | <input type="checkbox"/> Mood change | <input type="checkbox"/> Stealing | |
| <input type="checkbox"/> Drug or Alcohol usage | <input type="checkbox"/> No remorse | <input type="checkbox"/> Suicidal/Homicidal thoughts | |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Over-dependency | <input type="checkbox"/> Tearful | |

Other problems not listed above: _____

When did these problems first begin? _____

Have you noticed any sudden changes in behavior and moods recently? Yes No. If yes, explain:

Have there been any changes in the last six months? _____

For female adult client only: Are you currently nursing? Yes No.
Are you currently pregnant? Yes No.

For child client only: Were there any problems during the pregnancy or complications with labor? Yes No.
If yes, explain:



Kansas Children's Service League

Are you currently attending therapy? Yes No.

If yes, with whom, how often and is it helping?

For child client only: Was your child delayed in developmental milestones such as walking, talking, sitting up alone, dressing self, ECT? If so, please explain:

Has the client had problems with any of the following?

- Allergies to medication? Yes No, if yes please explain: _____
- Head injury? Yes No, if yes please explain: _____
- Head injury resulting in loss of consciousness? Yes No, if yes please explain: _____
- Heart Conditions? Yes No, if yes please explain: _____
- Diabetic? Yes No, if yes please explain: _____
- Seizures? Yes No, if yes please explain: _____
- Thyroid problems? Yes No, if yes please explain: _____
- Other medical problems? Yes No, if yes please explain: _____

Who is the client's medical doctor?

Is the client currently on any medications including vitamins and/or herbal remedies? Yes No

If yes, please list the medications and reason for taking:

<u>Medication</u>	<u>Reason</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____



Kansas Children's Service League

Any past psychiatric medications the client has been on in the past:

<u>Medication</u>	<u>did it help?</u>	<u>Any bad reactions? Explain.</u>
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Has anyone in the client's biological family been diagnosed with?

	Yes	No	If yes, relationship to client
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cognitively delayed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	_____

Client or Parent/Guardian if Minor Client Signature: _____

Relationship: _____

Today's Date: _____