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+

How did you hear about KCSL? _____

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

Outpatient Mental Health Services
1365 N Custer Wichita, KS 67203
Phone 316-686-6671 *Fax* 316-686-1094

Kansas Children's Service League

PARENT/GUARDIAN INFORMATION (if minor)

Name: _____ _____ _____

First Middle Last

Date of Birth: _____ **Social Security #:** _____ **Phone Number:** _____

Home Address: _____ _____ **Email:**_____

Street **Apt#**

_____ _____ _____

City: **State:** **Zip code:**

INSURANCE INFORMATION

Primary Insurance: _____ **Subscriber Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Employer:_____

Secondary Insurance:_____ **Subscriber Name:** _____

Date of Birth _____ **Social Security Number:** _____

Employer: _____

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**

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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:

☐ Abdominal Pain	☐ Fire setting	☐ Running away	☐ Temper tantrums
☐ Anxiety	☐ Headaches	☐ Sex problems	☐ Thumb sucking
☐ Clumsiness	☐ Hyperactivity	☐ Sexual/Physical/Emotional Abuse	☐ Toilet problems
☐ Cruelty	☐ Impulsive	☐ Sleep Problems	☐ Under-activity
☐ Depression/Sadness	☐ Lying	☐ Staring Spells	
☐ Destructiveness	☐ Mood change	☐ Stealing	
☐ Drug or Alcohol usage	☐ No remorse	☐ Suicidal/Homicidal thoughts	
☐ Eating problems	☐ Over-dependency	☐ 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 your currently pregnant? ☐ Yes ☐ No.

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

_____

_____

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:

	Medication	**Reason**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

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

Medication	**did it help?**	**Any bad reactions? Explain.**
1._____	☐Yes ☐No	_____
2._____	☐Yes ☐No	_____
3._____	☐Yes ☐No	_____
4._____	☐Yes ☐No	_____

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

	Yes	No	If yes, relationship to client
ADHD	☐	☐	_____
Anxiety	☐	☐	_____
Depression	☐	☐	_____
Bipolar	☐	☐	_____
Cognitively delayed	☐	☐	_____
Panic Attacks	☐	☐	_____
Schizophrenia	☐	☐	_____

Client or Parent/Guardian if Minor Client Signature: _____

Relationship: _____ Today's Date: _____