FamilyAttachment

COUNSELING CENTER

SOCIAL SKILLS CLENT DATA SHEET

(TO BE KEPT IN THE FRONT OF THE CHART)

Admit__________

Discharge__________

Client Name:____

Present mailing address:____

Phone:______________________________

Who child is currently living with and relationship to child:______________________________

IDENTIFICATION:

DOB:____________Race:__________________Religion:______________________________
Weight:________Height:__________Eye Color:_____________Hair Color:______________
Who has legal custody:____
Is the child adopted, foster, biological:____

PRESENTING PROBLEMS:

EXPECTATIONS:

SCHOOL INFORMATION:

School last attended:____________________________IEP? Y or N Present Grade:__________

Name and **phone number** of:
Teacher:____

Social Worker:____

Special Ed Teacher:____

Psychologist:____ Phone #:__________

MEDICAL INFORMATION:

Child's Physician:______________________ Phone #:______________________

Child's Psychiatrist:______________________ Phone #:______________________

COMPLETE ONLY IF FOSTER CHILD:

Agency/County having financial responsibility:______________________

County worker/case worker:______________________ Tel:______________________

Address:______________________

CURRENT FAMILY INFORMATION:

Father's name:______________________

Street Address:______________________City, State, Zip______________________

Home Tel:____________Cell Tel:____________Work Tel:____________

Place of employment:______________________

Mother's name:______________________

Street Address:______________________City, State, Zip______________________

Home Tel:____________Cell Tel:____________Work Tel:____________

Place of employment:______________________

Marital Status:______________________

Please List and siblings with their DOB:______________________

IN CASE OF EMERGENCIES THE FOLLOWING PERSON(S) ARE AUTHORIZED TO PICK UP MY CHILD IF STAFF ARE UNABLE TO REACH ME.

Name:______________________Tel:______________________
Name:______________________Tel:______________________

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SOCIAL SKILLS PROGRAM: HEALTH HISTORY FORM

(To be completed by child's parent/legal guardian)

Child:________________________________ Person completing form:________________________

1. Does your child take medication for emotional/behavioral concerns? (Type, dose,frequency):____
2. Does your child take emdication for physical ailments (inhaler, insulin, etc.?)___________________
____
3. Does your child have food allergies: If yes, please describe:________________________________
____
4. Does your child have seasonal allergies? If yes, please describe:_____________________________
____
5. Does your child have any medication allergies?____
____

MEDICAL CONCERNS

1) Does your child have any of the following? Circle all that apply:
   A. Bedwetting
   B. Daytime soiling
   C. Daytime wetting
   D. Urinary infections
   E. None Apply
   F. Other Urinary/bowel conditions
   Please explain:______________________________________

2) Does your child have any of the following? Circle all that apply:
   A. Frequent stomach aches/pains/nausea
   B. Frequent constipation
   C. Frequent diarrhea
   D. Frequent vomiting
   E. None Apply
   Please explain:______________________________________

3) Does your child have any of the following? Circle all that apply:
   A. Frequent earaches/infections
   B. Sore throat/strep throat
   C. Frequent colds
   D. None Apply
   E. Nose Bleeds
   Please explain:______________________________________

4) Does your child have any of the following? Circle all that apply:
   A. Heart problems
   B. Asthma
   C. Diabetes
   D. Hearing loss
   E. Vision impairments
   Please Explain:______________________________________
   F. Speech impairments/delays
   Please explain:______________________________________
   G. None Apply

OTHER CONCERNS:

5) Does your child currently have or have they recently had any of the following? Circle all that apply:
   A. Head Lice
   B. Ringworm
   C. Athletes foot
   D. Ingrown toenails
   E. Impetigo
   F. Rash
   Please Explain:____________________________
   G. None Apply

6) Please list and childhood diseases your child has had:____

7) Does your child have any permanent and/or physical limitations or problems? Y or N
   Please list:____

8) Last doctor visit:________________ Doctor's name:____

IMMUNIZATION HISTORY

DPT (Diphtheria, Pertussis, Tetanus) 1.___2.___3.___4.___5.___
OPV (Polio vaccine) 1.___2.___3.___4.___5.___
MMR (Measles, Mumps, Rubella) 1.___2.___3.___4.___5.___
HEP B (Hepatitis B) 1.___2.___3.___4.___5.___
HIB (Hemophilus influneza) 1.___2.___3.___4.___5.___
TD (Tetanus Booster) 1.___2.___3.___4.___5.___

Mantoux Date:__________Results:______________

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Client Insurance Information

Client Name: ______________________________ Male Female
Please circle last name

Address: ______________________________

Date of Birth: ______________

Home Telephone: ______________ Work Telephone: ______________

Primary Insurance: ______________________________

Name of insured: ______________________ Date of Birth: __________
(if other than client)
Insurance Address: ______________________________

Insurance Phone: ______________

ID and Group #: ______________

Secondary Insurance: ______________________________

Name of insured: ______________________________
(if other than client)
Insurance Address: ______________________________

Insurance Phone: ______________

ID and Group #: ______________

Authorization to Bill Insurance

I understand that full payment of all charges is my responsibility. I authorize Family Attachment and Counseling Center to bill my insurance company for all appropriate charges. I understand that any applicable co-payment and deductible are due at the time services are rendered. I authorize my insurance company to make payment of medical benefits to Family Attachment and Counseling Center for appropriate services.

______________________________ ______________
Authorized Signature Date

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Consent for Social Skills Services

RE: Name: ___________________________________

DOB: ____________________________________

I request that above named individual be admitted to that Family Attachment Center's Day Treatment Program. I understand that this is a group program consisting of group therapy, life skills, social skills and recreation therapy. I further understand that family therapy may be a part of my child's treatment plan and I/we are willing to participate in those sessions. I understand that day treatment services are provided to children with many different backgrounds and therapeutic needs. Within the context of therapy, appropriate confidential information may be discussed however, every attempt will be made to maintain confidentiality outside the group therapy setting. I have been informed that parents are encouraged to attend the initial treatment planning meeting and subsequent treatment plan reviews. I understand that day treatment sessions are 3 hour in length and that the published rate is $30.00 per hour.

Date: ____________________________________

____________________________________	____________________________________
Client Signature	Guardian Signature
____________________________________	____________________________________
Client's Printed Name	Guardian's Printed Name

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Consent for Behavior Management

RE: Name: ______________________________

DOB: ______________________________

Parent/Guardian
I understand that the staff at the Family Attachment Center's day treatment program may need to use behavior management techniques with the above named child during the course of the day treatment program. Such techniques would be used in situations to stop/prevent injury to self or others, and would be discontinued when the child demonstrates sufficient self-control and the immediate threat of harm has passed. These techniques may include discipline, timeouts and or physical restraints such as a basket hold. I give my informed consent for such techniques to be implemented when necessary with this child.

______________________________ ______________________________
Guardian Signature Date

____
Guardian's Printed Name

Child
I understand that the day treatment staff may need to use discipline, timeouts and or physical restraints such as a basket hold to keep me and other safe during the course of the day treatment program. I give my informed consent for the use of such behavior management techniques if necessary.

______________________________ ______________________________
Child Signature Date

____
Child's Printed Name

MEDICATION ADMINISTRATION CONSENT FORM

Client Name:_________________________,_____________________________DOB:___________________
Address:____Tel:___________________

PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION BY SOCIAL SKILLS STAFF

I have prescribed the following medication for this child and request that it be given during social skills operating hours.

Medication:____

Dosage and time of administration____
Instructions for giving medication____
Possible side effects____
Purpose or condition for which prescribed____

Medication:____

Dosage and time of administration____
Instructions for giving medication____
Possible side effects____
Purpose or condition for which prescribed____

PHYSICIAN'S SIGNATURE:_____________________________________DATE:_______________
ADDRESS:____PHONE:_____________

PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION

I request this medication be given as prescribed. I release the social skills staff from any liability in relation to the administration of the medication.

PARENT/GUARDIAN:____DATE:_______________

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The Family Attachment and Counseling Center Social Skills Staff have my permission to take (my child) ________________________________ to Thorpe Park for recreation therapy.

Signed,

____