Special Needs Services

Michelle Sage Chekan, J.D.

CLIENT INFORMATION FORM

A. Identification

Today's Date ____/____/____

Your child's name: ____DOB: ___/___/____Age: ______

Other names you/the Child have used (maiden, nicknames, aliases) or preferred name: ______________________

Address: _____________________________________City: ______________ State: ____ Zip: ____________

Home phone number: _________________ Work number:_________________ Cell Phone: _______________

Email: ______________________________

Driver's license #: ________________ Other ID #: ________________ State: _____

Disability(ies): ____

____

Racial/ethnic identities:____

Religious/spiritual traditions or identity: ____

B. Health

Child's general level of health? ❑Excellent ❑Good ❑Fair ❑Poor

❑Ritalin/other stimulants ❑Steroids ❑Hormones ❑Emetics (to vomit) ❑Laxatives

❑Other chemicals: ❑Medications____

Describe any allergies to medications:____

PCP/Pediatrician/Clinic/doctor's name: ____

Phone: _________________ Address: ____

C. Family

Legal Guardian (if not self): ____

Brothers or sisters (or stepbrothers/stepsisters): ____

Other members of your family: ____

Hospitalizations or surgeries:____

Other important family issues (losses, adoption, stepparents, other relatives): ______________________________

D. School (if applicable)

School your child goes to: ___________________________________ Grade level/year: ______________

Years of formal schooling have your Child had: ____

Subjects that are hardest for him/her: ____

Is he/her having problems in school? If so, describe: ____

Child will graduate with a diploma or a certificate of completion: _______________________________________

Child will be continuing high school until the age of 26: ____

E. Work/Employment (if applicable)

Does your child work? ❑No ❑Yes. If yes, how many hours a week? ________

Job title: ______________________________________ Location: ____

Problems at work? If so, please describe: ____

F. Special Needs

What is your child's diagnosis? Please list all different diagnosis:

____

MET/ Dates: ____

IEP/Dates: ____

504/Dates; ____

G. Social/Leisure Activities

Please describe what you like to do for fun/leisure activities and how often:____________________________________

____

Hours per day does your child spends online: ____ Watching TV: ____ Listening to music: ______

Check any of these your child enjoys using: texting, email, Facebook, Instagram, Twitter, other (specify):

____

H. Concerns

Request information or answers in any of these areas: ❑Governmental agencies ❑special needs organizations ❑Help with IEPs/METs ❑Guardianship/Power of Attorney ❑Medications ❑Wills and Estate information ❑Special needs trust ❑Training and jobs ❑Other (please specify): ____

Biggest worries or upsets you most when thinking about your child's future:

____

I. Emergency Contact information

Name: ____ Phone: _______________ Relationship:_______________
Address: ____

J. Referral

Name: ____________________________________Phone: ____

Address: ____

N. Children

Please indicate your/the Child's siblings and age below (please also include any stepchildren, adopted children, etc).

____Age:

____Age:

____Age:

O. Other

Anything else I should know that doesn't appear on this or other forms, but that is or might be important:

❑No ❑Yes If yes, please indicate:____

X_________________________________ _____________________________ ____/____/____

Signature of client (or parent/guardian/representative) Printed Name Date

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CONSENT AND AGREEMENT FOR SERVICES

I understand that the purpose of this evaluation is to provide information about _________________(the Child) for this purpose:

- ❑ Treatment planning
- ❑ Entry into a program
- ❑ Eligibility for services (specify): ______________________________
- ❑ Other (specify):______________________________

I understand that a report of the findings of this assessment will be sent to you.
You will be responsible for disclosure or distribution of this report.

I understand that these services may include face-to-face interviewing or administering tests, questionnaires, checklists, applications, and other assessment methods.

I understand that there is a fee for this/these service(s) and I agree to pay the fee discussed with Special Needs Services. I understand that I am fully responsible for payment for these costs and payments.

I agree to cooperate and help as much as I can by supplying full and accurate answers and making a sincere effort.

X______________________________ ______________________ ___/___/___

Signature of client (or parent/guardian) Printed Name Date

I, the Case worker, have discussed the issues above with the client (and/or his or her parent or guardian) and answered any questions raised.

X______________________________ ___/___/___

Signature of Case worker Date

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AUTHORIZATION TO RELEASSE CONFIDENTIAL INFORMATION

A. I, ______________________, Date of birth: ____/____/____, Social Security #: _______________, understand that the purpose of this release is to assist with my/this Child's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the Child's life.

B. To further this goal, I authorize Special Needs Services to release the below-specified information regarding me/the Child to the individual(s) listed below, and to receive information from them in any format including by telephone. I am aware of the risks to privacy of the use of electronic means of information transfer, and I accept these.

C. The information to be disclosed is marked by an × in the boxes below, and any items not to be released have a line ~~drawn~~ through them:

- ❑ Name of my therapist(s) ❑Name of case manager ❑Name(s) of treatment program(s)
- ❑ Diagnoses ❑Prognoses ❑Treatment plan ❑Scheduled appointments and attendance
- ❑ Progress notes ❑Compliance with treatment ❑Discharge plans ❑Treatment summary
- ❑ Psychological or other evaluations ❑Medications ❑Other: ____

D. This information is to be disclosed to these persons, who have the indicated relationship to me/the Child:

Name of person:________________________________ Relationship:______________________________________

Name of person:________________________________ Relationship:______________________________________

E. I understand that I may revoke this ROI authorization at any time, but that doing this will not bring back the information that was released before the date of the revocation. If I do not void or cancel this ROI authorization, it will automatically expire 1 year from the date I signed it.
F. I understand the consequences if I refuse to allow this release. My consent is fully voluntary.
G. I understand that the Source of the information has no control of it after it has left the Source's premises.
H. My/the Child's receiving treatment signature below indicated that I fully understand this ROI and authorize this release that can assist my/the Child's treatment.
I. Signatures:

X_______________________________________ ____________________________ ____/____/____

Signature of client (or parent/guardian/representative) Printed Name Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

X_______________________________________ ____________________________________ ____/____/____

Signature of witness Printed name Date