



### Enrollment and Demographic Form

Referral Date: \_\_\_\_\_

Child Information

1. Child's Name: \_\_\_\_\_ 2. SS#: \_\_\_\_\_

3. County: \_\_\_\_\_ 4. Date of Birth: \_\_\_\_\_ 5. Age: \_\_\_\_\_

6. Gender: MALE FEMALE

7. What is the child's race? (Circle Below)

White	Black/African American	Asian	American Indian	Hispanic	Bi-Racial	Other
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Funding and Income

1. What funding helps pay for the child's mental health expenses? (Circle all that apply)

Medicaid	SSI	CHIPS	Caregiver's Insurance	Other:
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2. Caregiver's Annual Income Range:

Less than \$5,000	\$5,000-\$9,999	\$10,000-\$14,999	\$15,000-\$19,999	\$20,000-\$24,999
\$25,000-\$34,999	\$35,000-\$49,999	\$50,000-\$74,999	\$75,000-\$99,999	\$100,000 or more

System Involvement

Please mark all systems the child is involved in below.

✓	System	Where	Who
	Mental Health		
	Social Services (CPS, Youth Services)		
	Educational (School child attends)		
	Health (Pediatrician, Family Doctor)		
	Substance Abuse Treatment		
	Juvenile Probation		
	After School Programs, Clubs, Camps, etc		
	Vocational (Training or Schools)		

	Other		
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Referral Source

Your Name: \_\_\_\_\_

Your Organization: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred the family to you? \_\_\_\_\_

What relationship does the referral source have to the family? (Please circle one)

Self	Family Member	Friend	DHHR worker	Mental Health
JPO, judge or attorney	Teacher, principal, or other education staff	Doctor/Nurse	Other:	

Caregiver and Family History

1. Who is the legal guardian of the child? \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

2. Who does the child live with? (If same as above leave blank) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

3. What is the caregiver's relationship to the child? \_\_\_\_\_

4. What is the age of the caregiver? \_\_\_\_\_ 5. Gender of Caregiver: \_\_\_\_\_

6. # of Adults in home (age 19 or older): \_\_\_\_\_ # of Children in home (including this child): \_\_\_\_\_

7. Does the Caregiver work? YES NO

8. Education of Caregiver: (Please circle highest level)

Graduate High School	Graduate from a professional School	Has a two year degree	Has a 4 year degree	Has a Master's degree	Has a doctorate Degree	Other:
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9. In the child's biological family has any of the following occurred? (Biological should be considered to include parents, siblings, as well as grandparents, aunts, uncles and those related by blood not marriage.) (Circle all that apply)

Domestic Violence in a home where the child has lived	Mental Illness of a biological parent	Mental Illness of another biological family member
Biological Parent has been in jail or prison	Another Biological Family Member has been in jail or prison	Biological Parent has problems with alcohol or drugs
Other Biological Family Member has problems with alcohol or drugs	Other:	Other:

10. Is the child currently at home or at a hospital, residential facility, or in another out-of-home placement? (Please circle)

HOME      PLACEMENT OUTSIDE OF HOME: \_\_\_\_\_

If out of home, how long has he/she been out of home? \_\_\_\_\_

Presenting problems

1. Circle all of the problems your child is having now:

Sad or Depressed	Anxious/Nervous	Hurts Self	Suicidal Thoughts	Suicide Attempt
Physically Aggressive	Verbally Aggressive	Physically Hurts Others	Has Sexually Hurt Another Child	Cruel to Animals
Hyper	Inattentive	Problems at School	Truancy	Low Self Esteem
Psychosis	Sexually Acting Out	Eating Disorder	Sleep Disorder	Avoids Social Situations
Problems with Peers	Runaway	Fire Setting	Crime with Police Contact	Drugs/Alcohol
Other:		Other:		

2. Has your child ever experienced any of the following? (Circle all that apply)

Psychiatric Hospitalization	Neglect	Physical Abuse	Sexual Abuse	Verbal Abuse from someone else
Attempted Suicide	Sexually abused another child	Runaway	Other:	

3. What is/are your child's diagnosis: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

4. Has your child ever been diagnosed with Mental Retardation? YES NO

If yes, is it: Mild Moderate Severe

5. Has your child ever been diagnosed with Autism? YES NO

6. Does your child have any physical problems such as asthma, migraines, etc? YES NO

List problems: \_\_\_\_\_

\_\_\_\_\_

7. List medications for physical problems: \_\_\_\_\_

8. List medications for psychiatric problems: \_\_\_\_\_

9. Does the child have a CAFAS score? YES NO

If Yes, Date Administered: \_\_\_\_\_ Total Score: \_\_\_\_\_

10. Does the child have a CANS score? YES NO

If yes, Date Administered: \_\_\_\_\_ Total Score: \_\_\_\_\_

11. If the Child is being referred to KidsCare, what is their:

Full Scale IQ: \_\_\_\_\_

Performance IQ: \_\_\_\_\_

Verbal IQ: \_\_\_\_\_

*Office Use Only:* Date of Enrollment: \_\_\_\_\_ ID# \_\_\_\_\_