Case#: _____
Admission Date: _____

Orange County Department Of Mental Health
Child and Family Outpatient Clinic
Application For Services

GENERAL INFORMATION

Legal Name:_____
(No Abbreviations Or Nick Names) (Last) (First) (Middle)

Sex: □ Male □ Female Date Of Birth:_____Age_____

Address:_____
(Street)
_____
(Mailing Address, if different)
_____
(City) (State) (Zip Code) (County)

Home Phone: (____) - _____ - _____

Cell Phone : (____) - _____ - _____

Work Phone: (____) - _____ - _____

Employer: _____ Occupation: _____

Primary Language: _____

Race: _____ Black ____ White ____Native American

Ethnic Group:
Hispanic ____ Central American ____ Columbian ____Cuban ____Dominican ____Ecuador han ____ Mexican ____ Puerto Rican ____Filipino ____ Haitian ____ Jamaican ____ Middle Eastern ____ Other _____

Place Of Birth:_____
(City) (State) (Country)

Marital Status □ Single □ Married □ Separated □ Divorced □ Widowed

Living Arrangements: □ **House** □ **Apartment** □ **Other_____**

Number Living In Household (Please list below beginning with self):

NAME	DATE OF BIRTH	OCCUPATION	RELATIONSHIP
			SELF

Veteran: □ **Yes** □ **No** □ **Unknown**

Military Related Disability: □ **Yes** □ **No**

Military Branch Of Service:_____

Military Service From: _____To_____

Contact Person (If other than Client):

_____ Relationship to Client _____
(Name)

_____
(Street)

_____
(City) (State) (Zip Code)

_____

Phone Number: _____

Is This The First Time You Have Received Services At This Clinic? □ **Yes** □ **No**

Reasons For Contact:
□ **Seeking Meds**
□ **Counseling**
□ **Other_____**

Issues You Want To Address In Treatment:

1. _____
2. _____
3. _____

Have You Ever Been Treated For Emotional Or Mental Health Problems:

□ **Yes** □ **No**

(Please list all, including past treatment at Orange County Mental Health Clinic)

DATE	DOCTOR OR AGENCY	REASON

Any Disabilities/Handicaps?_____

Education History:	School Name	City/Town	Highest Grade Completed	Date Graduated
Nursery School				N/A
Pre-School				N/A
Grade School (K-8)				
High School (9-12)				
College				
Vocational/Trade				

If Currently In School:

School_____Current Grade_____

Education Type: □ **Regular** □ **Special Ed** □ **Other _____**

This Application Was Completed By:

Signature_____

Permission To Contact After Discharge: Yes No

Permission To Treat A Minor

I Authorize Orange County Mental Health Clinic To Provide Services To My Child,_____, For Such Treatment As Recommended By One Of Your Staff. This May Include The Prescribing Of Medication By Your Medical Staff, Only With My Knowledge.

Signature Of Parent Or Guardian: _____
(Signature)

_____
(Print Name)

_____
(Date)

_____
(Witness)

CHILD AND FAMILY CLINIC
HEALTH/NURSING ASSESSMENT

NAME: _____ DOB: ____/____/____DATE: ___/____/____

PHYSICAL HEALTH

Height _____ Weight _____ Eye Color _____ Hair Color _____

Cultural/Language Needs _____

Last Physical Examination: _____ **By Whom**: _____

MEDICAL HISTORY

Allergies: □ None □ Food □ Drug □ Environment □ Unknown

Other Allergies:_____

Allergic Reactions:_____

***Immunization History (Adolescents*)** □ Up to date □ Missing_____

Date of Last Menstrual Period: ____/____/____

Last PPD □ Positive □ Negative □ Unknown

Chest X-ray □ Yes □ No Comments_____

Alert/Illnesses Information:
□ Diabetic □ Seizures □ Heart Condition □ Possible Pregnancy
□ Tuberculosis □ Thyroid □ Ulcers □ Hepatitis
□ Mumps □ Scarlet Fever □ Chicken Pox □ Measles/Rubella
□ Rheumatic Fever □ Respiratory □ High Blood Pressure
□ Blurred vision □ Ringing in ear □ Dizziness □ Head Injuries
□ Discomfort in chest □ Frequent Nausea □ Tendency to bleed
□ Other, specify_____

Current Medications and Dosages: _____
_____

Do you take your medications as prescribed? □ Yes □ No

HEALTH HABITS

Appetite □ **Decreased** □ **Increased** □ **Unchanged**
Comment:_____

Sleep □ Decreased □ Increased □ Unchanged
Comment:_____

Energy Level □ Decreased □ Increased □ Unchanged
Comment:_____

Exercise □ Yes □ No
Comment:_____

Tobacco Use □ Yes □ No
Quantity_____**How Long**_____

Drug Use □ Yes □ No
If yes, please answer the following:

Alcohol use last drink _____ How Long _____
Last drug use _____ How Long _____

Have you ever felt you should cut down on drinking/drug use?
□ Yes □ No □ N/A □ Unknown

Have people annoyed you by criticizing your drinking/drug use?
□ Yes □ No □ N/A □ Unknown

Have you ever felt guilty about your drinking/drug use?
□ Yes □ No □ N/A □ Unknown

Have you ever had a drink/drug in the morning to steady your nerves or rid hangover?
□ Yes □ No □ N/A □ Unknown

Do you take any of you medication differently than prescribed?
□ Yes □ No □ N/A □ Unknown

Do you take medications aside from the ones prescribed?
□ Yes □ No □ N/A □ Unknown

FAMILY HISTORY

Biological Family (Include current age, if deceased age and cause of death

Patient _____

Mother_____

Father_____

Sibling_____

Sibling_____

Sibling_____

Sibling_____

Other_____

Family Illnesses (Indicate if biological family has had any of the following and include relationship to the patient being seen here).

Tuberculosis _____ **Diabetes_____**
High Blood Pressure_____ **Heart Problems_____**
Cancer_____ **Epilepsy_____**
Blood Disease_____ **Mental Illness_____**
Alcohol Use/Abuse_____ **Drug Use/Abuse_____**
HIV/AIDS_____ **Other_____**

Family Doctor (medical):_____

Address:_____

Phone: (____) - _____ - _____
Current Medications (Both psychiatric and medical)
_____
_____

ADL & RISK FACTORS

Do you need assistance with any of the following?
□ Walking □ Dressing □ Bathing □ Oral Hygiene
□ Elimination

Check all that apply □ Use of Cane □ Use of Walker □ Use of Other
Comments:_____

Client/Family Teaching Needs
□ Medication Information □ Problem Solving/Stress Management
□ Exercise/Rest □ Symptom Management
□ Other _____

If client is under 18 years old, please complete the following

BIRTH & DEVELOPMENT HISTORY

Please check if yes:
Pregnancy □ Prenatal Care □ Drugs/Alcohol/Cigarettes □ Illness/meds

Condition of Birth Birth Weight ___lbs ___oz

Delivery □ Full Term □ Premature □ C Section

Infancy Problems □ Feeding □ Sleeping □ Responding to environment

Any complications in the hospital before going home?_____
_____

Milestones – Please provide age at which the child performed the following:

Walked without support ___ Spoke first word ____
Spoke 1st 3-word sentence ____Toilet trained – Urine___Bowels____

Comments _____
_____
_____

PRESENT PROBLEMS OR SYMPTOMS
(check all that apply)

Hearing difficulties
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Visual problems
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Headaches
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Ear Infections
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Nosebleeds
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Colds
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Wets bed at night
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Wets self during the day
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Has bowel movements in bed at night
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Has uncontrollable bowel movement during the day
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Rocks in bed
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Rocks in a chair
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Complains of pains in the abdomen
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Is hyperactive
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Sucks his or her thumb
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Has trouble falling asleep
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Tires easily
□ Not at all □ A little □ A fair amount □ Much □ Very Much

Please list any other physical symptoms or problems the child has, any surgery or hospitalizations._____
_____