Aurora Family Service®

Today's Date: _____

Client's Name: _____ **Legal Name (if different):** _____

Pronouns (he/she/they/something else): _____

Client's Age: _____ **DOB** (mm/dd/yyyy): _____ **Social Security #:** _____

Address: _____
(Street) (City) (Zip)

Parent/Legal Guardian's Name (If under 18): _____**DOB**: _____

Home Number: _____ **Work:** _____ **Cell:** _____

What is the best way of getting a hold of you? ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Is it safe to leave a voicemail message identifying as Aurora Family Service staff? ☐ Yes ☐ No **Please indicate any restrictions:** _____

What is the best time of the day to get a hold of you?

☐ Early Mornings ☐ Late Mornings ☐ Early Afternoon ☐ Late Afternoon ☐ Early Evening

Emergency Contact Name: _____ **Phone Number:** _____

Emergency Contact's relationship to the client: _____

Gender identity: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Sex assigned at birth: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Sexual Orientation: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Race: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Ethnicity: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Religious / Spiritual Orientation: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Ability / Disability Status: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Relationship Status: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Primary Language Spoken at Home: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
Highest Level of Completed Education: _____ **or ☐ prefer not to answer ☐ unsure how to answer**
What aspects of your identity are most important to you or will help your therapist to understand you better? Please list:

_____

_____

Name of Employer (Client or Parent): _____ **Occupation:** _____

Employment Status: ☐ Employed (FT) ☐Employed (PT) ☐Employed (temp) ☐Retired ☐Unemployed ☐Student ☐Other:_____

Annual *Household* income? ☐$0 - $9,999 ☐$10,000 - $14,999 ☐$15,000 - $24,999 ☐$25,000 – $36,999 ☐$37,000 - $49,999 ☐$50,000 - $74,999 ☐$75,000 or more ☐Free & reduced price lunch

If paying for sessions yourself, how much can you pay per session? _____

Insurance Information:

Name of Insurance: _____**Client Subscriber ID**: _____ **Group #**: _____

Name of Subscriber: _____**Subscriber DOB**: _____ **Subscriber Social Security #:** _____

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Please list additional family members who also live in the household:

Name	DOB	Relationship to Client

New Client Questionnaire & Health History

Please complete this form in its entirety to the best of your ability.

If you are filling this form out on behalf of a child or adolescent, please respond in relation to the child/adolescent.

1. **What has brought you in today? What is the problem or concern you want our help with?**

_____
_____
_____
_____

2. **Please describe any values, beliefs, customs, traditions or practices that are important to you and/or your family that you think would be helpful for us to know about to better serve you?**

_____
_____
_____
_____

3. **Stressors and struggles:** Is *anyone* in the household experiencing the following? Check all that apply.

		Complete for Children/Adolescents
☐ Parent/child conflict	☐ Partner violence/abuse	☐ School failure/performance decline
☐ Couple concerns	☐ Sexual abuse/rape	☐ Truancy/running away
☐ Anger issues	☐ Alcohol/drug use	☐ Fighting with peers
☐ Depression/hopelessness	☐ Loss/grief	☐ Fighting with adults
☐ Anxiety/worry	☐ Legal issues/probation	☐ Hyperactivity
☐ Communication problems	☐ Eating problems/disorders	☐ Wetting/soiling clothes
☐ Divorce adjustment	☐ Sexuality/intimacy concerns	☐ Child abuse/neglect
☐ Remarriage adjustment	☐ Suicidal thoughts/attempts	☐ Isolation/withdrawal
☐ Job problems/unemployed	☐ Major life changes	

☐ Other: (please describe) _____

4. **Symptoms:** Are you (is your child) experiencing any of the following health related symptoms? Check all that apply.

☐Panic	☐Recklessness	☐Lost of interest in activities
☐Restlessness/Fidgety	☐Impulsivity	☐Difficulty concentrating
☐Stomachaches	☐Irritability	☐Hallucinations
☐Headaches	☐Intrusive Thoughts	☐Unexplained significant weight loss or gain (5lbs or more)
☐Dizziness	☐Obsessions	☐Changes in Sleep, if yes, sleeping ☐ More? ☐ Less?
☐Chronic Pain	☐Compulsive Behavior(s)	☐Changes in Appetite, if yes, eating ☐ More? ☐ Less?
☐Euphoria	☐Fatigue/Tiredness	☐Other: _____

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5. **Are you (or your child/adolescent) in need of accommodations?** ☐Yes ☐No

   ☐Language interpretation ☐Literacy ☐Transportation ☐Sliding fee scale ☐Other: _____

6. **Has anyone in the family ever been treated in the past or present for mental health?** ☐Yes ☐No

   (If yes, when and under what circumstances?):_____

   _____

   Name of Professional: _____*Name of Facility*: _____

   Address: _____

7. **Do you (does your child) have a doctor or somewhere you go when needing health care?** ☐Yes ☐No
   If you answered yes, please state the name of the Doctor and the Facility if known.

   Name of Doctor: _____*Name of Facility*: _____

   Address: _____

   Is this an Aurora Health Care related doctor and/or facility? ☐Yes ☐No

8. **Does anyone in the family have a chronic health condition(s)?** ☐Yes ☐No

   (**If yes, please specify**): _____

9. **Are you (Is your child) currently taking any medication(s)?** ☐Yes ☐No

   (**If yes, please specify**): _____

10. **Have you (has your child) stopped taking medication in recent months?** ☐Yes ☐No

    (**If yes, please specify**): _____

11. **Have you (has your child) participated in special education services in school?** ☐ Yes ☐ No
12. **Are you, or anyone else concerned about alcohol or drug use in the family?** ☐ Yes ☐ No
13. **Has Child Protective Services been involved in your life? (past or present)** ☐ Yes ☐ No
14. **Are you (is your child) participating in treatment under a court order?** ☐ Yes ☐ No
15. **Are you (is your child) currently involved in any legal proceedings**? ☐ Yes ☐ No
16. **Have you (has your child) ever lost a loved one to homicide?** ☐ Yes ☐ No
17. **Have you (has your child) ever lost a loved one to suicide?** ☐ Yes ☐ No
18. **Do you (does your child) have a history of self-harming, suicidal thoughts or attempts?** ☐ Yes ☐ No
19. **Do you have current safety concerns for yourself, child or others**? ☐ Yes ☐ No
20. **Is there anything else that you think would be helpful for us to know?**

_____

_____

_____

_____

For Office Use Only

This document has been reviewed in its entirety.

_____ _____

Provider Signature Date