FRASER

CLIENT NAME

DATE OF BIRTH

CLIENT NAME	Last	First	M.I.

DATE OF BIRTH	(M/D/Y)	**TODAY'S DATE**	(M/D/Y)

PERSON ANSWERING QUESTIONS	Last	First	Relationship to Client

SECTION A: PRESENTING CONCERNS

Please describe primary concerns for client.
Examples may include: aggression, social withdrawal, poor grades, tantrums, depression, anxiety, etc.

CONCERN	**AGE AT FIRST OCCURRENCE**	**FREQUENCY** (e.g., daily)	**DURATION** (e.g., less than 5 minutes)	**PROBLEM RATING 0-10** (mild 1, severe 10)

SECTION B: FAMILY AND LIVING SITUATION

1. Where does the client currently live or has previously lived?

TYPE OF HOUSING	**PAST**	**CURRENT**	**TYPE OF HOUSING**	**PAST**	**CURRENT**
Family Home	☐	☐	Residential Treatment Center	☐	☐
Lives Independently	☐	☐	Group Home	☐	☐
Adoptive Home	☐	☐	Halfway House	☐	☐
Relative/Extended Family Home	☐	☐	Correctional Facility	☐	☐
Foster Care (Formal, Shelter, or Kinship)	☐	☐	Homeless	☐	☐
Orphanage	☐	☐	Inpatient Psychiatric Facility	☐	☐
Emergency Shelter Facility	☐	☐			
Other (please explain)				☐	☐

2. Does the client live alone? ☐ **Yes** ☐ **No**
If no, please select all that apply and fill in necessary information

	NAME(S)	**AGE(S)**	**OCCUPATION(S)**	**HIGHEST EDUCATION**
☐ Parent(s)				
☐ Adoptive Parent(s)				
☐ Foster Parent(s)				
☐ Sibling(s)				
☐ Spouse/Partner ☐ Children ☐ Relative ☐ Roommate ☐ Other:				

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3. Fill out the following only for minor clients (under age 18), if applicable.

Are the parents separated or divorced? ☐Yes ☐No ☐Never Married ☐ N/A
If parents are separated or divorced, please select the applicable custody status. ☐ Sole legal ☐Joint legal ☐Sole physical ☐Joint physical ☐ Other ☐N/A

If applicable, please describe the visitation schedule:

	Mother	Father	Other	How often does this parent see the client?			
Parent 1	☐	☐	☐	☐Weekly or more often	☐Once or twice a month	☐Few times a year	☐ Never
Parent 2	☐	☐	☐	☐Weekly or more often	☐Once or twice a month	☐Few times a year	☐ Never

Have the parental rights of the parents been terminated? ☐ Yes ☐No ☐Unknown ☐ N/A

4. Fill out the following for adult clients (18 and up), if applicable.

Does the client have a guardian? ☐Yes ☐No ☐Unknown If yes, please describe

SECTION C: FAMILY HISTORY

1. Are there any relatives of the client (including parents, siblings, grandparents, aunts, uncles, or cousins) who have any of the following conditions? **☐Yes ☐No ☐Information Unavailable**

MEDICAL ISSUES	RELATION TO CLIENT	MOTHER'S OR FATHER'S SIDE
☐Convulsions, Seizures		☐ Mother's ☐ Father's
☐Indentified Syndromes		☐Mother's ☐Father's
☐Genetic Disorders		☐Mother's ☐Father's
☐Heart-related Concerns		☐Mother's ☐Father's
☐ Diabetes		☐Mother's ☐Father's
☐ Other		☐ Mother's ☐Father's
DELAYS/DIFFICULTIES	**RELATION TO CLIENT**	**MOTHER'S OR FATHER'S SIDE**
☐Developmental Delay		☐Mother's ☐Father's
☐Intellectual Disability		☐Mother's ☐Father's
☐Learning Disabilities		☐Mother's ☐Father's
☐Reading Difficulties		☐Mother's ☐Father's
☐ School Difficulties		☐Mother's ☐Father's
☐ Speech/Language Problems		☐Mother's ☐Father's
☐ Delayed Motor Development		☐Mother's ☐Father's
☐ Other		☐Mother's ☐Father's
MENTAL HEALTH	**RELATION TO CLIENT**	**MOTHER'S OR FATHER'S SIDE**
☐ADHD		☐Mother's ☐Father's
☐Anxiety		☐Mother's ☐Father's
☐Autism/Asperger's/Pervasive Developmental Disorders (PDD)		☐Mother's ☐Father's
☐ Bipolar Disorder		☐Mother's ☐Father's
☐ Depression		☐Mother's ☐Father's
☐ Psychosis		☐Mother's ☐Father's
☐Obsessive-Compulsive Disorder		☐Mother's ☐Father's
☐Schizophrenia		☐Mother's ☐Father's
☐Trauma		☐Mother's ☐Father's
☐Other Mental Illness		☐Mother's ☐Father's

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SUBSTANCE ABUSE	RELATION TO CLIENT	MOTHER'S OR FATHER'S SIDE
☐ Alcoholism		☐Mother's ☐Father's
☐ Drug Use		☐Mother's ☐Father's
☐ Prescription Pill Abuse		☐Mother's ☐Father's
☐ Substance Use Treatment		☐Mother's ☐Father's
☐ Other		☐Mother's ☐Father's
LEGAL	**RELATION TO CLIENT**	**MOTHER'S OR FATHER'S SIDE**
☐ Convictions		☐Mother's ☐Father's
☐ Incarcerations		☐Mother's ☐Father's
☐ Other		☐Mother's ☐Father's

SECTION D: INDIVIDUAL AND CULTURAL CONSIDERATIONS

1. What ethnicity does the client identify with?

☐American	☐Hispanic/Latino	☐Somali
☐Asian	☐Hmong	☐Vietnamese
☐East African	☐Korean	☐West African
☐European	☐Russian	☐Not Disclosed
☐Other (Please describe)		

2. What race does the client identify with?

☐American Indian or Alaskan Native	☐Black or African American	☐White
☐Asian	☐Native Hawaiian or Pacific Islander	☐Multiracial
☐Not Disclosed	☐Other (Please describe)	

3. Does the client identify with a faith or spiritual community? ☐ **Yes** ☐ **No** ☐ **Unknown**

If yes, what is your religious/spiritual belief/affiliation?

SECTION E: BASIC NEEDS AND SUPPORT SYSTEM

1. Is the client/family currently accessing any community resources for support? ☐ **Yes** ☐ **No**

COMMUNITY SERVICE	DESCRIPTION
☐ Advocacy Services (i.e., The Arc, PACER)	
☐ Case Management	
☐ County Services	
☐ Employment Services	
☐ Food Support (i.e., SNAP)	
☐ Housing Support (i.e., Section 8, GRH, MSA)	
☐ In-Home Health Support (i.e., Nurse)	
☐ Medical Assistance	
☐ PCA Care/Respite Care	
☐ Social Security	
☐ Social Worker	
☐ Transportation (i.e., Metro Mobility, medical transportation)	
☐ Waiver Services	
☐ WIC	
☐ Other	

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2. Are there any other basic needs that are not currently being met?

☐ **Yes, I need help.** ☐ **No, basic needs are met and do not require assistance.**

If yes, please select all that apply: ☐ **Clothing** ☐ **Food** ☐ **Financial Support** ☐ **Housing** ☐ **Medical Care** ☐ **Transportation** ☐ **Other**

3. Does the client feel supported by any of the following?

☐ Clubs or Groups	☐ School Activities
☐ Community	☐ Significant Other
☐ Counselor/Therapist/Service Provider	☐ Social Network
☐ Extended Family	☐ Substance Support Group/Sponsor
☐ Religious Affiliations	☐ Other:

SECTION F: CLIENT MEDICAL AND DEVELOPMENTAL HISTORY

1. Were there any prenatal/birth issues worth noting for the client? ☐ **Yes** ☐ **No** ☐ **Unknown/Information not available**

If yes, please answer questions below:

PRENATAL/BIRTH ISSUE	YES	NO	UNKNOWN	DESCRIPTION
Client's mother had pregnancy complications	☐	☐	☐	
Client's mother used medications during pregnancy	☐	☐	☐	
Client was exposed to prenatal substances	☐	☐	☐	
Client's mother had delivery complications	☐	☐	☐	
Client was born preterm (<37 weeks)	☐	☐	☐	
Client had low/high birth weight	☐	☐	☐	
Client's mother had perinatal complications	☐	☐	☐	
Client's mother experienced postpartum depression	☐	☐	☐	

2. Developmental history of client when he/she was under age 6

GROSS MOTOR DEVELOPMENT	YES	NO	UNKNOWN	N/A	COMMENTS
Rolled by 7 months	☐	☐	☐	☐	
Crawled/creeped by 11 months	☐	☐	☐	☐	
Clapped or brought hands together in front of body to hold a toy by 11 months	☐	☐	☐	☐	
Walked by 18 months	☐	☐	☐	☐	
Toilet trained by 3.5 years	☐	☐	☐	☐	
LANGUAGE DEVELOPMENT	**YES**	**NO**	**UNKNOWN**	**N/A**	**COMMENTS**
Babbled by 5 months	☐	☐	☐	☐	
Used first words by 12 months	☐	☐	☐	☐	
Combined words by 24 months	☐	☐	☐	☐	

3. Screening Review

SCREENINGS/EXAMS	YES	NO	N/A	DATE (MM/YYYY)
Date of last physical exam is known	☐	☐	☐	
Date of last dental exam is known	☐	☐	☐	
Date of least hearing screening is known	☐	☐	☐	
Date of last vision screening is known	☐	☐	☐	

Is the client up to date with early childhood immunizations?

☐ **Yes** ☐ **No** ☐ **Unknown** ☐ **Choose not to vaccinate**

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4. Does client have any of the following significant medical conditions? ☐ **Yes** ☐ **No** ☐ **Unknown/Information not available**

If yes, please select all that apply:

SIGNIFICANT MEDICAL CONDITIONS	PAST	CURRENT	DESCRIPTION
Asthma	☐	☐	
Seizures	☐	☐	
Food Restrictions	☐	☐	
Food Allergy — If Yes, is epinephrine injection (EpiPen) required? Yes ☐ No ☐	☐	☐	
Insect Sting Allergy — If Yes, is epinephrine injection (EpiPen) required? Yes ☐ No ☐	☐	☐	
Medication Allergies — If Yes, is epinephrine injection (EpiPen) required? Yes ☐ No ☐	☐	☐	
Environmental Allergies	☐	☐	
Diabetes	☐	☐	
G-tube (i.e., feeding tube)	☐	☐	
Vision Impairment (i.e., blind)	☐	☐	
Hearing Impairment (i.e., deaf)	☐	☐	

5. Does client have any of the following? ☐ **Yes** ☐ **No** ☐ **Unknown/Information not available**

If yes, please select all that apply:

OTHER MEDICAL CONDITIONS	PAST	CURRENT	DESCRIPTION
Surgeries	☐	☐	
Serious Accident(s)	☐	☐	
Head Trauma/Concussion	☐	☐	
Infectious Disease	☐	☐	
Vision Problems	☐	☐	
Appetite/Eating Concerns	☐	☐	
Sleep Concerns	☐	☐	
Frequent Headaches	☐	☐	
Frequent Stomachaches	☐	☐	
General Aches and Pains	☐	☐	
Sexualized Behavior Concerns	☐	☐	
Sexual Health Concerns (i.e., STD)	☐	☐	
Other Medical Concerns	☐	☐	

SECTION G: MEDICATIONS

1. List any <u>current</u> medications for both <u>physical and mental health</u> purposes:

MEDICATION NAME	REASON FOR PRESCRIPTION	DOSAGE	PRESCRIBED BY	MEDICATION HELPFUL? Y/N

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2. List any past medications for mental health purposes:

MEDICATION NAME	REASON FOR PRESCRIPTION	DOSAGE	PRESCRIBED BY	WHY DISCONTINUED

SECTION H: MEDICAL AND MENTAL HEALTH SERVICES

1. Has the client participated in any evaluations or diagnostic assessments pertinent to the current concerns?

☐ **Yes** ☐ **No** ☐ **Unknown/Information not available**

If yes, please select all that apply:

TYPE OF ASSESSMENT	DATE OF SERVICE	AGENCY	RESULTS OR DIAGNOSIS
☐ Diagnostic Assessment			
☐ Feeding Therapy Evaluation			
☐ Genetic Evaluation			
☐ Neurologic Evaluation			
☐ Neuropsychological Evaluations			
☐ Occupational Therapy Evaluation			
☐ Physical Therapy Evaluation			
☐ Psychiatric Evaluation			
☐ Psychological Evaluation			
☐ Speech Therapy Evaluation			
☐ Other			

2. Has the client participated in any services pertinent to the current concerns?

☐ **Yes** ☐ **No** ☐ **Unknown/Information not available**

If yes, please select all that apply and indicate date, agency, and results of evaluations/diagnosis given.

TYPE OF SERVICE	LAST DATE OF SERVICE	AGENCY	FREQUENCY	RESULTS OR DIAGNOSIS
☐ABA				
☐ARMHS				
☐Career Planning and Employment				
☐Crisis Support				
☐Day Treatment				
☐Family Therapy				
☐Feeding Therapy				
☐Group Skills				
☐Group Therapy				
☐Individual Skills				
☐Individual Therapy				

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TYPE OF SERVICE	LAST DATE OF SERVICE	AGENCY	FREQUENCY	RESULTS OR DIAGNOSIS
☐ Occupational Therapy				
☐ Partial Hospitalization				
☐ Physical Therapy				
☐ Psychiatric Hospitalization				
☐ Psychiatry/Medication Management				
☐ Speech Therapy				
☐ Substance Use Treatment				
☐ Other:				
☐ Other:				
☐ Other:				

SECTION I: SERVICE PROVIDERS AND COORDINATION OF CARE

1. Primary Care Provider

Primary Care Provider Name	Clinic Name	Phone Number

2. Dental Provider

Dental Provider Name	Clinic Name	Phone Number

3. Is the client currently seeing, or has recently seen, any of the following providers?

☐Yes ☐No ☐ Unknown/Information not available

If yes, please select all that apply:

MEDICAL PROFESSIONAL	CLINIC/PROVIDER NAME
☐ Allergist	
☐ Audiologist	
☐ Developmental Pediatrician	
☐ Feeding Clinic	
☐ Gastroenterologist	
☐ Geneticist	
☐ Mental Health (Non-Fraser)	
☐ Neurologist	
☐ Ophthalmologist	
☐ Pediatric Therapy (Non-Fraser)	
☐ Other:	
☐ Other:	
☐ Other:	

4. Preferred Emergency Care Provider (Hospital of preference in an emergency)

Emergency Care Name:	Phone Number:

5. Emergency Contact for the Client (Other than primary guardian(s) or parent(s))

Name:	Relationship:

Cell Phone:	Home Phone:	Work Phone:

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SECTION J: STRESS AND TRAUMA

1. Has the client experienced or witnessed any of the following, resulting in distress?

EXPERIENCE	AGE OF OCCURRENCE/DESCRIPTION
☐ Adoption/International Adoption	
☐ Car Accident	
☐ Community Violence	
☐ Custody Conflict	
☐ Death	
☐ Divorce/Separation	
☐ Domestic Violence/Abuse	
☐ Family Conflicts	
☐ Family Medical/Mental Health Issues	
☐ Family Substance Abuse/Use	
☐ Fire	
☐ Frequent Moves	
☐ Immigration	
☐ Medical	
☐ Military Deployment	
☐ Natural Disaster	
☐ Out-of-Home Placement	
☐ Phyical Illness	
☐ Separation from Parent	
☐ Sexual Assault/Molestation	
☐ Unsafe Neighborhood/Community	
☐ Other:	

SECTION K: CLIENT LEGAL ISSUES

1. Has the client been involed in any legal issues?

☐ **Yes** ☐ **No**

If yes, please select all that apply:

LEGAL ISSUES	PAST	CURRENT	LEGAL ISSUES	PAST	CURRENT
Adult Protection	☐	☐	CPS Involvement	☐	☐
Alcohol and Drug-Related	☐	☐	Guardian ad litem	☐	☐
Awaiting Charge	☐	☐	Juvenile Detention	☐	☐
Convictions	☐	☐	On Parole	☐	☐
Court-Ordered Treatment	☐	☐	Other:	☐	☐

If Other, please explain:

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SECTION L: SCHOOL INFORMATION

1. Is the client in school? ☐ **Yes** ☐ **No**
If No, check the highest level of schooling completed.

☐ Pre-School	☐ Middle School	☐ Certificate/Trade Program	☐ Bachelor's or Higher
☐ Kindergarten	☐ High School/GED	☐ Some College	☐ Unknown
☐ Elementary School	☐ Transition Programming	☐ Associate Degree	

If Yes, fill in the following information.

a. Name of current school:

b. Check the client's current grade in school:

☐ ECSE	☐ 2nd Grade	☐ 7th Grade	☐ 12th Grade
☐ Childcare	☐ 3rd Grade	☐ 8th Grade	☐ Certificate/Trade Program
☐ Pre-School	☐ 4th Grade	☐ 9th Grade	☐ Associate's Degree
☐ Kindergarten	☐ 5th Grade	☐ 10th Grade	☐ Bachelor's or Higher
☐ 1st Grade	☐ 6th Grade	☐ 11th Grade	☐ Other

c. Has the client ever been on a 504 plan? ☐ **Yes** ☐ **No** ☐ **Unknown**
If Yes, describe:

d. Has the client ever been on an Individual Education Plan (IEP)/Individualized Family Services Plan (IFSP)?

☐ **Yes** ☐ **No** ☐ **Unknown**
If Yes, please select all that apply:

IEP/IFSP	PAST	CURRENT	IEP/IFSP	PAST	CURRENT
Autism Spectrum Disorder	☐	☐	Blind-Visually Impared	☐	☐
Deaf-Blind	☐	☐	Deaf, Hard of Hearing	☐	☐
Developmental/Cognitive Disability	☐	☐	Dev. Delay/Early Childhood Special Ed.	☐	☐
Emotional/Behavioral Disorder	☐	☐	Other Health Disability	☐	☐
Physical Impairment	☐	☐	Specific Learning Disability	☐	☐
Speech/Laguage Impairment	☐	☐	Traumatic Brain Injury	☐	☐
Unsure/Documentation Unavailable	☐	☐			

e. Has the client ever received any of the following services in school? ☐ **Yes** ☐ **No** ☐ **Unknown**
If Yes, please select all that apply:

SCHOOL SERVICES	PAST	CURRENT	COMMENTS
Academic Support (e.g., reading, math)	☐	☐	
Gifted and Talented/Enrichment	☐	☐	
Occupational Therapy	☐	☐	
Paraprofessional Support	☐	☐	
Physical Therapy	☐	☐	
Social Skills	☐	☐	
Speech Therapy	☐	☐	
Study Skills	☐	☐	
Other:	☐	☐	

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f. Has the client had attendance or academic issues in school? ☐ **Yes** ☐ **No** ☐ **Unknown**

If Yes, please select all that apply

ATTENDANCE/ACADEMIC ISSUES	PAST	CURRENT	ATTENDANCE/ACADEMIC ISSUES	PAST	CURRENT
Problems with Grades	☐	☐	Suspensions/Expulsions	☐	☐
Problems with Attendance	☐	☐	Repeated Grades	☐	☐
Other:	☐	☐			

SECTION M: EMPLOYMENT INFORMATION

1. What is the client's employment status?

☐ Full-Time Employed	☐ Unemployed and would like employment
☐ Part-Time Employed	☐ Not Employed (e.g., too young, not seeking employment, unable to work)

SECTION N: SAFETY/RISK ASSESSMENT

1. Does the cient demonstrate any safety/risk concerns? ☐ **Yes** ☐ **No**

SAFETY/RISK CONCERNS	PAST	CURRENT	SAFETY/RISK CONCERNS	PAST	CURRENT
Self-Harm Statements	☐	☐	Self-Harm Actions	☐	☐
Suicidal Ideation	☐	☐	Suicidal Attempt	☐	☐
Dangerous Behaviors to Others	☐	☐	Destruction of Property	☐	☐
Risk of Wandering/Running Away	☐	☐	Threatens to Harm Others	☐	☐

2. Is there a safety plan in place? ☐ **Yes** ☐ **No**

SECTION O: CLIENT/FAMILY STRENGTHS

Please describe client/family strengths:
What does the client do well and enjoy doing?
What do others and family enjoy about the client?
What does the family like doing together?