



CLIENT INFORMATION FACE SHEET

Client Information: Please complete this section regarding the client

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Date of Birth: _____ **Social Security Number:** _____ **Alias Name(s):** _____

Gender: Male Female Transgender-Male to Female Transgender-Female to Male

Client Address: _____
 Street City County State 9 Digit Zip Code

Client Name at Birth: _____

Check which phone number below is "Primary" and which phone number below is the Appointment Reminder #.

Home Phone: _____ **Primary #?** **Appointment Reminder #?**

Cell Phone: Name: _____ **#:** _____ **Primary #?** **Appointment Reminder #?**

Preferred Communication Method: (Check one) Email Home Phone Work Phone Cell Phone

Email: _____ **Email:** _____

Email owner name: _____ **Email owner name:** _____

Client Marital Status: Never Married Married Divorced Separated Widowed Common Law

Race: American Indian or Alaska Native Black or African American Native Hawaiian or Other Pacific Islander

Asian White Other / Unknown: _____ **Ethnicity:** Hispanic / Latino Yes No

Military Status: (check one) Client Active / Has Served N/A

Client Employer: _____ **Occupation:** _____ **Work Phone:** _____

Allergies: Please list all known allergies to medication, food, animals, etc.

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Parent / Legal Guardian and Household Information:

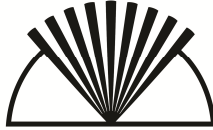
Parent Name	Gender	Date of Birth	SSN	Relationship to the Client	Legal Guardian	Household Member	Emergency Contact
Address: _____				Cell Phone: _____			
Employer: _____		Work Phone: _____		Home Phone: _____			
Parent Name	Gender	Date of Birth	SSN	Relationship to the Client	Legal Guardian	Household Member	Emergency Contact
Address: _____				Cell Phone: _____			
Employer: _____		Work Phone: _____		Home Phone: _____			

Legal Guardian Name (If Not the Parent)	Daytime Phone	Relationship to the Client		Household Member	Emergency Contact
Address:			Employer:		
Legal Guardian Name (If Not the Parent)	Daytime Phone	Relationship to the Client			
Address:			Employer:		
Emergency Contact Person Not Living with the Client	Daytime Phone	Relationship to the Client			
Other Household Members Name(s)	Date of Birth	Relationship to the Client	FSGC Current Client?		

This information is correct to the best of my knowledge _____
Signature _____ Date _____

FSGC USE ONLY - MONTHLY HOUSEHOLD INCOME:			
Wages, Salary, self-employed (includes Workers' Comp).....	_____		_____
Public Assistance (Medicaid) /Unemployment Insurance.....	_____		_____
Retirement/pension (includes SSI and SSDI)	_____		_____
Child Support/Alimony.....	_____		_____
Other.....	_____		_____
Number supported by this Income: _____		Sub Total.....	\$ _____
Sliding Fee Scale Percentage: _____		Subtract Child Support Paid.....	\$ _____
		Total Income.....	\$ _____

Client Name: _____



FAMILY SERVICE &
GUIDANCE CENTER

CLIENT ADMISSION INFORMATION - Child / Adolescent

CLIENT'S HIGHEST LEVEL OF EDUCATION ACHIEVED

(Please select (X) one)

10	None	24	High School Graduate (Not GED)
11	Preschool	25	One Year of College
12	Kindergarten	26	Two Years of College (Inc. Assoc Degree)
13	First Grade	27	Three Years of College
14	Second Grade	28	Bachelor Degree
15	Third Grade	29	Graduate Work (No Degree)
16	Fourth Grade	30	Master's Degree
17	Fifth Grade	31	Doctorate Degree
18	Sixth Grade	32	Special Education Un-graded Class
19	Seventh Grade	33	General Education Degree (GED)
20	Eighth Grade	34	Vocational Training Beyond High School
21	Ninth Grade	35	Unknown
22	Tenth Grade	36	Four Years of College (No Degree)
23	Eleventh Grade	37	MD
		38	JD (Attorney)

EDUCATIONAL PLACEMENT

(Please select (X) current educational placement)

1	Not applicable (not listed below)	13	Not in school (GED)
2	Institutional instruction: e.g. psych. Hospital, detention	14	Not in school (expelled)
3	Residential School	15	Not in school (drop-out)
4	Home-based instruction from school district	16	Preschool
6	Special Ed. Classroom	17	Other
7	Regular classroom with Special Ed. Services or Consultation	18	Alternative Education placement with Intensive Psychosocial
9	Regular classroom (100% of the day, no Special Ed.)	19	Not in School – Summer Break
10	Home Schooling not provided by the school district	20	Therapeutic Services for Preschool Children
11	Not in school (suspended)	21	Enrolled in Post Secondary Education (Technical School, College, Professional Development such as Cosmetology)
12	Not in school (graduated)		

Name of school attending: _____

SUPPLEMENTAL DETERMINATION BENEFITS (SSI or SSDI)

(Please Check One)

<input type="checkbox"/> 1. Not Applicable;	<input type="checkbox"/> 2. Eligible and Receiving Payments;
<input type="checkbox"/> 3. Eligible but not Receiving Payments;	<input type="checkbox"/> 4. Potentially Eligible (Case not yet Submitted for Determination)
<input type="checkbox"/> 5. Determined to be Ineligible by Review and Decision.	<input type="checkbox"/> 6. Determination Decision on Appeal

Client Name: _____

RESIDENTIAL SETTING

(Please select the current residential setting by placing an "X" before the selection)

1	Jail / Detention	8	Emergency Shelter
2	State Hospital	9	Therapeutic Foster Care
3	Inpatient Psychiatric Unit	10	Foster Home
4	Crisis Resolution/Stabilization Unit	11	Temporarily living with a Relative or Family Friend
5	Drug/Alcohol Treatment Center	12	Home of Parent(s): Biological, Adoptive, or Legal
6	Residential Treatment/Level VI	13	Independent Living
7	Group Home (level III, IV, V)	14	Homeless

JUVENILE JUSTICE & LAW ENFORCEMENT

(Please report the number of each category based on the previous 30 days)

Total number of arrests	# of adjudicated misdemeanors
# of adjudicated felonies for property crimes	# of law enforcement contacts (face-to-face contact not resulting in arrest)
# of adjudicated felonies for crimes against persons	# of adjudicated felonies not property or persons
	Not Applicable

CURRENT OR PREVIOUS MENTAL HEALTH TREATMENT:

(Please select (X) all that apply)

		Name of the Facility / Provider	Estimated Last Treatment Date
1	No previous treatment		
2	State mental health hospital Enter the county where the client lived independently or with family for six continuous months prior to the latest admission to the State Hospital.		
3	Private psychiatric hospital		
4	Out of Home Crisis Stabilization		
5	General Hospital Psychiatric Unit		
6	Inpatient Substance Abuse (excluding detox, etc.)		
7	Residential mental health treatment within a state correctional facility		
8	Therapist		
9	Medication Management Provider		
10	Other:		
11	Other:		

CURRENT OR PREVIOUS MEDICAL HEALTH TREATMENT:

(Please enter the information for all that apply)

Provider Type	Name of the Facility / Provider and Location (ie. Topeka, Rossville)	Estimated Last Treatment Date
Primary Care Physician:		
Other Medical Provider:		
Other Medical Provider:		
Other Medical Provider:		
Other Medical Provider:		

CUSTODY STATUS

(Please select the current residential setting by placing an "X" before the selection)

1	Child in JJA Custody and Lives at Home	5	Child is Under DCF Supervision, But Not in their Custody
2	Child in JJA Custody and Out of Home Placement	6	Child is Under Supervision of JJA, But Not in their Custody
3	Child is in DCF Custody and Lives at Home	7	No JJA or DCF Involvement
4	Child is in DCF Custody and Out of Home Placement		