SARATOGA CENTER FOR THE FAMILY
Building stronger families for stronger communities

Client Information Sheet – Child

Child's Legal Name _____ Date of Birth _____ Age _____

Child's Preferred Name _____ Gender Identity _____

Preferred Pronouns _____ County of Residence _____

Address _____

Child's Primary Custodial Parent/Guardian is: □ Mother □ Father □Both parents □ Other

1.Parent/Guardian Name _____ Relationship _____

Address _____

Phone Number(s) _____

Currently Employed □ No □ Yes If Yes, Occupation _____

2.Parent/Guardian Name _____ Relationship _____

Address _____

Phone Number(s) _____

Currently Employed □ No □ Yes If Yes, Occupation _____

3.Parent/Guardian Name _____ Relationship _____

Address _____

Phone Number(s) _____

Currently Employed □ No □ Yes If Yes, Occupation _____

4.Parent/Guardian Name _____ Relationship _____

Address _____

Phone Number(s) _____

Currently Employed □ No □ Yes If Yes, Occupation _____

Parent/Guardian(s) are currently: □ Married □ Divorced □ Remarried □ Never Married □ Other

Who referred you or how did you hear about Saratoga Center for the Family?

□ Social Services □ Court □ School □ Saratoga County Mental Health □ Other:

SARATOGA CENTER FOR THE FAMILY
Building stronger families for stronger communities

Insurance/Payment information

Client Legal Name: _____

Client Date of Birth: _____

Primary Care Physician: _____ Phone: _____

Does the client have health insurance? ☐ Yes ☐ No

If yes, complete below. If no, inquire about our Financial Assistance Program.

Insurance Company Name _____

Insurance Member ID Number _____

Group Number _____

Name of Policy Holder _____ Relationship _____

Policy Holder's Date of Birth: _____

Policy Holder's Place of Employment _____

I authorize release of any medical or other information to my insurance company as necessary to obtain payment incompliance with the Health Insurance Privacy and Portability Act (1996). I also authorize payment of benefits directly to Saratoga Center for the Family. Additionally, I understand that I am responsible for any fees not paid by the insurance company. This includes fees associated with deductibles, co-insurance, co-payments and out of network charges.

Signature: _____ Date _____

Printed Name: _____

Relationship to Client: _____

Please notify us if your insurance changes in any way. It is your responsibility to inform Saratoga Center for the Family if your insurance terminates or changes. You will be responsible for all charges incurred due to a lapse or change in insurance coverage.

SARATOGA CENTER FOR THE FAMILY
Building stronger families for stronger communities

Pediatric Symptom Checklist

Emotional and physical health often go together in children. Because parents/guardians/caregivers are often the first to notice a problem, you may help us provide the best possible care by answering these questions. Please mark which best fits your child within the past month.

		Not at all	A little/ Sometimes	Often
1	Complains of aches/pains	☐	☐	☐
2	Spends more time alone	☐	☐	☐
3	Tires easily, has little energy	☐	☐	☐
4	Fidgety, unable to sit still	☐	☐	☐
5	Has trouble with a teacher	☐	☐	☐
6	Loss of interest in school	☐	☐	☐
7	Acts as if driven by a motor	☐	☐	☐
8	Excessive Daydreaming	☐	☐	☐
9	Easily Distracted	☐	☐	☐
10	Is afraid of new situations	☐	☐	☐
11	Feels sad/unhappy	☐	☐	☐
12	Is irritable/angry	☐	☐	☐
13	Feels hopeless	☐	☐	☐
14	Has trouble concentrating	☐	☐	☐
15	Has increased anxiety	☐	☐	☐
16	Loss of interest in friends	☐	☐	☐
17	Has trouble with friends/peers	☐	☐	☐
18	Fights with others	☐	☐	☐
19	School grades dropping	☐	☐	☐
20	Has trouble sleeping	☐	☐	☐
21	Worries excessively	☐	☐	☐
22	Needs constant attention	☐	☐	☐
23	Feels s/he is 'bad'	☐	☐	☐
24	Takes unnecessary risks	☐	☐	☐
25	Gets hurt frequently	☐	☐	☐

		Not at all	A little/ Sometimes	Often
26	Acts younger than children his/her age	☐	☐	☐
27	Does not follow rules	☐	☐	☐
28	Is disruptive of family routines	☐	☐	☐
29	Has obsessions/compulsions	☐	☐	☐
30	Suffers from memory loss	☐	☐	☐
31	Has auditory or visiual hallucinations	☐	☐	☐
32	Does not show feelings	☐	☐	☐
33	Does not understand other people's feelings	☐	☐	☐
34	Blames others for his/her troubles	☐	☐	☐
35	Takes things that do not belong to him/her	☐	☐	☐
36	Has sudden or extreme mood swings	☐	☐	☐
37	Used drugs or alcohol	☐	☐	☐
38	Engages in repetitious behaviors	☐	☐	☐
39	Has specific fears/phobias	☐	☐	☐
40	Suffers from flashbacks of an upsetting event	☐	☐	☐
41	Has gender dysphoria	☐	☐	☐
42	Engages in self-harm (cutting, burning, rubbing, etc)	☐	☐	☐
43	Has been bullied by others	☐	☐	☐
44	Is physically aggressive	☐	☐	☐
45	Disregards rules in school or at home	☐	☐	☐
46	Disregards social norms or laws	☐	☐	☐
47	Over sexualized behavior or knowledge for age	☐	☐	☐
48	Enuresis (bed wetting or wetting pants)	☐	☐	☐
49	Encopresis (soiling of clothing or bedding)	☐	☐	☐
50	Suicidal thoughts or actions	☐	☐	☐

Psychosocial: What words best describe your child's social interactions with others? Check all that apply.

☐ Outgoing ☐ Talkative ☐ Extroverted ☐ Quiet ☐ Shy ☐ Introverted
☐ Makes friends easily ☐ Slow to make friends ☐ Bossy ☐ Is easily hurt by others
☐ Tends to want to do activities in groups ☐ Tends to want to do activities alone ☐ Has bullied peers
☐ Spends too much time on social media or playing video games ☐ Plays/participates well with others
☐ Is negatively influenced by social media or video games ☐ Shows good sportsmanship skills
☐ Is well liked by peers ☐ Is well liked by teachers and other adults ☐ Is bullied by others
☐ Is considerate of others ☐ Is considered mature for age ☐ Is considered immature for age
☐ Other

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure – Child (Age 6-17)

Child's Name: _____ **Age:** _____ **Today's Date:** _____

Instructions (for parent/guardian of child): The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the past TWO (2) WEEKS.

		During the past TWO (2) WEEKS, how much (or how often) has your child:	**None** Not at all	**Rare** less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly Every day	**Highest Domain Score** *(Clinician)*
I	1	Complained of stomachaches, headaches or other aches and pains?	0	1	2	3	4	
	2	Said s/he was worried about his/her health or about getting sick?	0	1	2	3	4	
II	3	Had problems sleeping – trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III	4	Had problems paying attention when s/he was in class, doing homework, reading, or playing a game?	0	1	2	3	4	
IV	5	Had less fun doing this than s/he used to?	0	1	2	3	4	
	6	Seemed sad or depressed for several hours?	0	1	2	3	4	
V	7	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI	8	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII	9	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII	11	Said s/he felt nervous, anxious, or scared?	0	1	2	3	4	
	12	Not been able to stop worrying?	0	1	2	3	4	
	13	Said s/he couldn't do things they wanted to or should have done because they made them feel nervous?	0	1	2	3	4	
IX	14	Said they heard voices wen no one was there telling them to do things or saying bad thing to them?	0	1	2	3	4	
	15	Said that s/he had a vision of something no one else could see when s/he was completely awake?	0	1	2	3	4	
X	16	Said that s/he had thoughts that kept coming into his/her mind that s/he would do something bad or that something bad would happen to him/her or someone else?	0	1	2	3	4	
	17	Said s/he felt the need to check on certain things over and over again – like whether a door was locked or the stove was off?	0	1	2	3	4	
	18	Seemed to worry a lot about this s/he touched being dirty or having germs, or being poisoned?	0	1	2	3	4	
	19	Said that s/he had to do things in a certain way, like counting, or saying special things out loud in order to keep bad things from happening?	0	1	2	3	4	

In the past TWO (2) WEEKS, has your child:

XI	20	Had an alcoholic beverage (beer, wine, liquor, etc)?	☐ Yes	☐ No	☐ Don't Know
	21	Smoked a cigarette, cigar, pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know
	22	Used Drugs like Marijuana, Cocaine or Crack, Ecstasy, LSD, Heroin, Meth, or inhaled solvents like glue?	☐ Yes	☐ No	☐ Don't Know
	23	Used any medicine without a doctor's prescription (like pain killers such as Vicodin), or stimulants (like Ritalin or Adderall) or sedatives/tranquilizers (like Valium or sleeping pills)?	☐ Yes	☐ No	☐ Don't Know
XII	24	In the past TWO (2) WEEKS, has s/he talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know
	25	Has your child EVER tried to kill himself or herself?	☐ Yes	☐ No	☐ Don't Know