

Serenity Mental Health Services  
 6613 Eastridge Road  
 Black Hawk, SD 57718  
 605-431-8595  
**Client Information**  
**Child Form**

**Name:**

\_\_\_\_\_  
 Last First M.I.

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

RACE: \_\_\_\_\_ GRADE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

Who suggested you contact us?: \_\_\_\_\_

With whom does your child live? \_\_\_\_\_

**MOTHER:**

\_\_\_\_\_  
 Last First M.I.

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

PHONE NUMBER: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

IF NECESSARY MAY WE CONTACT THIS PERSON AT HOME? Yes No

AT WORK? Yes No

OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

NUMBER OF SCHOOL YEARS COMPLETED: \_\_\_\_\_

CURRENT MARITAL STATUS (please list all)

Married Date: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced Date: \_\_\_\_\_

Widowed Date: \_\_\_\_\_

**FATHER:**

Last	First	M.I.
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ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

PHONE NUMBER: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

IF NECESSARY MAY WE CONTACT THIS PERSON AT HOME? Yes No  
AT WORK? Yes No

OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

NUMBER OF SCHOOL YEARS COMPLETED: \_\_\_\_\_

CURRENT MARITAL STATUS (please list all)

Married Date: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced Date: \_\_\_\_\_

Widowed Date: \_\_\_\_\_

**OTHER PARENTS/SIGNIFICANT CARETAKERS (if applicable):**

Last	First	M.I.
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ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

PHONE NUMBER: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_

IF NECESSARY MAY WE CONTACT THIS PERSON AT HOME? Yes No  
AT WORK? Yes No

OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

NUMBER OF SCHOOL YEARS COMPLETED: \_\_\_\_\_

CURRENT MARITAL STATUS

Married Date: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced Date: \_\_\_\_\_

Widowed Date: \_\_\_\_\_

**SIBLINGS** (if applicable):

NAME	SEX	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PSYCHOLOGICAL:**

Has your child received psychiatric or psychological help before?    Yes    No

If yes, please explain:

\_\_\_\_\_

\_\_\_\_\_

**PLEASE LIST ANY PSYCHIATRIC HOSPITALIZATIONS:**

Year	Hospital	Purpose of Hospitalization	Admitting Physician	Length of Stay
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**PLEASE INDICATE ANY FAMILY HISTORY OF PSYCHOLOGICAL PROBLEMS:**

Name	Relationship to Child	What was the problem?	Treatment	Given?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**EDUCATIONAL:**

What are your child's grades: \_\_\_\_\_

Is your child experiencing any problems with teacher's or classmates, attendance:

\_\_\_\_\_

\_\_\_\_\_

**VOCATIONAL:**

Child's work history (if applicable): \_\_\_\_\_

Child's employer: \_\_\_\_\_

Job description: \_\_\_\_\_

Number of hours worked each week: \_\_\_\_\_

**PREVIOUS JOBS:** (Please give approximate dates and length of employment)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL:**

What leisure activities or hobbies does your child enjoy?

\_\_\_\_\_  
\_\_\_\_\_

Does your child prefer doing activities alone or with others? \_\_\_\_\_

\_\_\_\_\_

What activities or hobbies does your child do with others? \_\_\_\_\_

\_\_\_\_\_

How many friends does your child have? \_\_\_\_\_Few \_\_\_\_\_Several \_\_\_\_\_Many

What clubs, organizations, or social activities does your child participate in on a regular basis? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL:**

CHILD'S PRIMARY PHYSICIAN: \_\_\_\_\_ DATE OF LAST VISIT: \_\_\_\_\_

REASON FOR LAST VISIT: \_\_\_\_\_

Please list any major health problems for which your child has received or is currently receiving treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list chronologically (from oldest to most recent) medications your child has used this year:

Medication	Purpose of Medicine	Prescribing Physician	Date Started/Stopped
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any medical hospitalizations and treatments:

Year	Hospital	Purpose of Hospitalization	Admitting Physician	Length of stay
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALCOHOL AND DRUG USE PROFILE:**

Has your child ever misused drugs, medications, or alcohol? Yes No

If yes, please explain: (age of first use, type of substance, frequency of use, etc.)

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Has your child ever received treatment for alcohol/other drug misuse? Yes No

If yes, please complete the following:

Year Place Length of stay/Number of sessions Did you complete the program?

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**ASSESTS AND LIMITATIONS:**

Please list several of your child's strengths:

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Please list several of your child's weaknesses:

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**WHAT BRINGS YOUR CHILD TO SERENITY MENTAL HEALTH?**

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**PROBLEM CHECK LIST:**

Please circle any of the following problems that your child is currently experiencing or has experienced in the past:

**Problem** How long have they had this?

Sibling conflict \_\_\_\_\_

Parents Separating \_\_\_\_\_

Parents Divorce \_\_\_\_\_

Bedwetting \_\_\_\_\_

Sexual Problems \_\_\_\_\_

Nervous \_\_\_\_\_

Fears \_\_\_\_\_

Difficulty Relaxing \_\_\_\_\_

Alcohol use \_\_\_\_\_

Legal Matters \_\_\_\_\_

Sleep problems \_\_\_\_\_

Tiredness \_\_\_\_\_

Ambition \_\_\_\_\_

Unhappiness \_\_\_\_\_

Sadness \_\_\_\_\_

Authority troubles \_\_\_\_\_

Anger \_\_\_\_\_

Self-control \_\_\_\_\_

My thoughts \_\_\_\_\_

Concentration \_\_\_\_\_

Homicidal thoughts \_\_\_\_\_

Headache \_\_\_\_\_

Low self-esteem \_\_\_\_\_

Lying \_\_\_\_\_

Other areas of concern \_\_\_\_\_

**Problem** How long have they had this?

Stealing \_\_\_\_\_

Conflict with Parents \_\_\_\_\_

Running Away \_\_\_\_\_

Friends/peers \_\_\_\_\_

Stomach trouble \_\_\_\_\_

Shy \_\_\_\_\_

Stress \_\_\_\_\_

Drug use \_\_\_\_\_

Fire setting \_\_\_\_\_

Finances \_\_\_\_\_

Nightmares \_\_\_\_\_

Suicidal Thoughts \_\_\_\_\_

Loneliness \_\_\_\_\_

Depression \_\_\_\_\_

Tearfulness \_\_\_\_\_

School \_\_\_\_\_

Temper \_\_\_\_\_

Memory \_\_\_\_\_

Making decisions \_\_\_\_\_

Confusion \_\_\_\_\_

Appetite \_\_\_\_\_

Bowel troubles \_\_\_\_\_

Past abuse \_\_\_\_\_