



Date: _____
Person(s) providing information: _____
Relationship to Client: _____
STAR Rewards Referral #: _____

Client Information

Client's Name: _____
Home Address: _____
City: _____ Zip: _____ County: _____ Gender: M F Age: _____
Birth Date: _____ Race: _____ Language(s): _____
School: _____ Grade: _____

Parent Information

Mother's Name: _____ Biological/ Stepmother/ Adoptive
Address: _____
Home Phone: _____ Cell Phone: _____
Occupation _____ Work Phone: _____
Race: _____ Birth Date: _____ Language(s): _____
Can you be contacted at work for non-emergency? Y N

Father's Name: _____ Biological/ Stepfather/ Adoptive
Address: _____
Home Phone: _____ Cell Phone: _____
Occupation _____ Work Phone: _____
Race: _____ Birth Date: _____ Language(s): _____
Can you be contacted at work for non-emergency? Y N

Other Family Member: _____ Grandparent/ Aunt/ Uncle/ _____
Address: _____
Home Phone: _____ Cell Phone: _____
Occupation _____ Work Phone: _____
Race: _____ Birth Date: _____ Language(s): _____
Can you be contacted at work for non-emergency? Y N

Family Information

All persons living in household now:

Table with 4 columns: Name, Age, Gender, Relationship to Child. Multiple rows for listing household members.



Does your child have dietary restrictions? N Y

What foods/liquids? _____

Any environmental allergies? To what: _____

Does your child have any physical/health limitations? N Y

To what? _____

Has your child been hospitalized for any reason since birth? N Y

For what? When? _____

Please list ALL medications your child is presently taking:

<u>Start Date</u>	<u>Drug Name</u>	<u>Reason</u>	<u>Prescribing Physician</u>
-------------------	------------------	---------------	------------------------------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

Please list medications your child has taken in the past, but is no longer taking, other than for normal childhood illnesses:

<u>Why Discontinued</u>	<u>Drug Name</u>	<u>Why Taken</u>	<u>Date Last Taken</u>
-------------------------	------------------	------------------	------------------------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

_____	_____	_____	_____
-------	-------	-------	-------

Educational Information

Does your child attend school currently? N Y

Name of School: _____ City: _____

Number of days attend per week: _____ Hours attend per day: _____

Any problems at school? N Y If yes, please describe: _____

Family Concerns

What is your primary goal for your child? _____

What two things do you think your child needs to change to be more successful in school, the community, or at home? _____

Cultural Information

What particular group or culture does your family identify with? _____

What specific religious or spiritual beliefs or traditions are important to your family? _____



