COMCARE of Sedgwick County
Children's Services – Initial Assessment Information

Today's Date	**Child's Name: Last**	**First**	**Middle**	**Other names known:**

Social Security No.	**Age**	**Gender**	**Date of Birth**	**Home Phone**	**Other Phone**

Address:	**City**	**State**	**Zip Code**

Parent/Guardian Name: Last	**First**	**Middle**	**Relationship to Child**

Address:	**City**	**State**	**Zip**

Race:
☐ Alaskan ☐ American Indian
☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ Native American
☐ White/Caucasian
☐ Other _____

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Education:
Current Grade: _____
School: _____
High School Graduate: ☐ Yes ☐ No
GED: ☐ Yes ☐ No
Special Education: ☐ Yes ☐ No
If Yes, what Class/Subject? _____

Are you able to Speak, Read, and/or Write in the following Language(s)? (Check all that apply)

☐ American Sign Language	☐ Filipino	☐ Italian	☐ Speak Limited English
☐ Arabic	☐ French	☐ Japanese	☐ Understand Limited English
☐ Chinese	☐ German	☐ Spanish	☐ Do Not Speak/Understand English
☐ Danish	☐ Hebrew	☐ English	☐ Other_____

Who Referred You to Comcare?_____

Custody Status:
☐ Child in Need of Care ☐ Juvenile Offender ☐ Both JO and CINC ☐ Does Not Apply

Have you had any involvement with: ☐ Day Reporting ☐ Family Preservation
☐ Foster Care ☐ Kansas Children's Service League

Family History: Provide the following information about parents and siblings.

Relationship	Name	Age	Location (city &State)

Is there any Mental Illness or Substance Abuse in family? ☐ Yes ☐ No

If Yes, please identify:_____

Emergency Contact Person (someone other than parent/guardian):

Name_____

Address: _____City:_____State:_____Zip_____

Home Phone:_____Other Phone:_____

Relationship to Child:_____

Medical History:

Primary Care Physician:_____ Psychiatrist/ARNP_____

Name of Clinic/Doctor's Office_____ Name of Clinic/DR Office:_____

Address:_____ Address:_____

City, State, Zip:_____ City, State, Zip:_____

Ph#_____ Ph#:_____

Medication and Dosage Currently Taken For Treatment of Prescribed By

Chemical Dependence History:

Is there now or has there ever been a problem with drug use (including alcohol, marijuana, cocaine, prescribed drugs, or any other drug)? ☐ Yes ☐ No If Yes, Identify what drug(s) and when:_____

Now or ever been in treatment program for any type of alcohol or other drug use? ☐ Yes ☐ No

If Yes, Identify what drug(s), when and where treated:_____

Attend any support group(s): ☐ Yes ☐ No If Yes, Identify which group(s): ☐ AA ☐ NA ☐ CA ☐ AL ANON ☐ Other:_____Now or ever received a DUI or DWI or OUI ☐ Yes ☐ No

If Yes, When?_____

Mental Health/Psychiatric Treatment and Hospitalization History:

Therapist, Psychologist, Psychiatrist, Counselor	Psychiatric Hospital, Mental Health Center, Counseling Center or Name of Doctor's Office	Dates of Service

Clear Form