# JF&CS CHILD INFORMATION FORM

**CHILD'S NAME:** ______________________________ **NICKNAME:** ______________________

Date of Birth: _____/______/______ Gender: ☐Female ☐Male ☐Transgender ☐Other

Address: ______________________________________________________________

Child's School: ______________________________ Child's Grade: ______________________

**FAMILY**

**Parent's Name:** ______________________________________________________________

Email: __________________________ Preferred Phone Number: _________________________

Address: (☐ Same as above) ______________________________________________

Relation to Child: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Aunt ☐Uncle ☐Other: __________

Guardian Status: ☐Biological ☐Adopted ☐Step ☐Other: ____________________________

Date of Birth: ___/___/___ Age: ______ Occupation: ______________________________

Race: ☐Caucasian ☐African American ☐Hispanic ☐Asian American ☐Other: ________________

Religion: ☐Jewish ☐Catholic ☐ Protestant ☐Other: __________ ☐Unemployed ☐Full Time Parent

**Parent's Name:** ______________________________________________________________

Email: __________________________ Preferred Phone Number: _________________________

Address: (☐ Same as above) ______________________________________________

Relation to child: ☐Mother ☐Father ☐Grandma ☐Grandpa ☐Aunt ☐Uncle ☐Other: ______________

Guardian Status: ☐Biological ☐Adopted ☐Step ☐Other: ____________________________

Date of Birth: ___/___/___ Age: ______ Occupation: ______________________________

Race: ☐Caucasian ☐African American ☐Hispanic ☐Asian American ☐Other: ________________

Religion: ☐Jewish ☐Catholic ☐Protestant ☐No Religion ☐Other: __________________________

**Parent Marital Status**: ☐Married ☐Never Married ☐Widowed ☐Divorced (___/___) ☐Separated (___/___)

Legal Custody: ☐Mother/Father ☐Mother ☐Father ☐Other: ______________________________

Physical Custody: ☐Mother/Father ☐Mother ☐Father ☐Other: ___________________________

Parenting Plan: ☐ N/A __________________________________________________________

**Others in Home:** __________________ Age: ________ Relation to Child: ______________
__________________ Age: ________ Relation to Child: ______________
__________________ Age: ________ Relation to Child: ______________
__________________ Age: ________ Relation to Child: ______________
__________________ Age: ________ Relation to Child: ______________

## DEVELOPMENTAL HISTORY

**Pregnancy:** Planned:☐ Yes ☐ No Complications: ______________________ Full Term: ☐ Yes ☐ No
Use of: ☐Drugs ☐Alcohol ☐Tobacco ☐Medications If yes, please describe: ________________________
Prenatal Care: ☐Yes ☐No

**Labor:** ☐Normal ☐Induced ☐C-section Birthplace/City: ___________________________________
Length of Labor: ___________________________ Length of Hospital Stay: ______________________

**Birth:** Weight: _____________ Complications: ☐Required oxygen at birth ☐Jaundice ☐colic
☐Allergies ☐Poor sucking ability ☐Poor weight gain

**Milestones:** Check any delays in the following milestones before age 7:

| | | |
|---|---|---|
| ☐Rolling over | ☐Speech | Please explain delays: |
| ☐Sitting | ☐Crawling | |
| ☐Walking | ☐Toileting | |
| ☐Running | ☐Feeding | |

**Early Childhood Problems:** Check any difficulties with the following before age 7:

| | |
|---|---|
| ☐Became easily frustrated | ☐Outbursts of uncontrolled behavior |
| ☐Preferred structured routine | ☐Difficulty with organizational skills |
| ☐Complained of physical pains | ☐Immature social interests |
| ☐Tried to control situations | ☐Need immediate gratification |
| ☐Nightmares | ☐Bedwetting |
| ☐Unusual Fears | ☐Aggression |
| ☐Difficulty with impulse control | ☐Difficulty taking turns with others |
| ☐Emotional sensitivity | ☐Difficulty making friends |

☐Difficulty following instructions or rules
☐Needed to change activities frequently or do something that someone else was doing
☐Difficulty forming relationships, making friends, or being accepted by peers
☐Other: ______________________________________________________________

## ACADEMIC & SCHOOL HISTORY

Repeated a grade: ☐No ☐Yes, Which One(s): ______________________________

Truancy: ☐No ☐Yes, Outcome: ______________________________

Suspensions: ☐No ☐Yes, How Many: ______________________________

Expulsions: ☐No ☐Yes, Outcome: ______________________________

Learning Disorder: ☐No ☐Yes, Please Specify: ______________________________

Gifted Program: ☐No ☐Yes, Since When: ______________________________

Individual Education Plan: ☐No ☐Yes, Current: ☐No ☐Yes Last Update: ________________

IEP Team Members: ______________________________________________________
______________________________________________________
______________________________________________________

Last Psychological Testing Date: ______________________________ ☐Provided a copy to JF&CS

**School Performance**

| Grade | Average Grades | Problems During Year |
|---|---|---|
| K | | |
| 1st | | |
| 2nd | | |
| 3rd | | |
| 4th | | |
| 5th | | |
| 6th | | |
| 7th | | |
| 8th | | |
| 9th | | |
| 10th | | |
| 11th | | |
| 12th | | |

**Extracurricular Activities:**

Current Activities: ______ Schedule: ______ Past Activities & Age: ______

Strengths/Interests/Hobbies: ______

**ENVIRONMENTAL STRESSORS**

Significant Death: ☐Yes ☐No Relation(s) to Child: ______

Significant Moves: ☐Yes ☐No Dates/Locations: ______

Child Medical Problems: ☐Yes ☐No Explain: ______

Family Medical Problems: ☐Yes ☐No Explain: ______

Financial Problems: ☐Yes ☐No Explain: ______

Abuse in Family ☐Yes ☐No Explain: ______

Addiction in Family ☐Yes ☐No Explain: ______

Violence in Family ☐Yes ☐No Explain: ______

Other: Explain: ______

## MENTAL HEALTH & MEDICAL HISTORY

| Counselor/Therapist Name: | Reasons for Visits: | Dates of Treatment: |
|---|---|---|
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |

| Psychiatrists: | Diagnosis(s): | Medication, Dosages, & Dates: |
|---|---|---|
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |

**Child's Medical Conditions**

Seizures: ☐Yes ☐No Explain: ________________________________________

Head injuries: ☐Yes ☐No Explain: ________________________________________

Prolonged fevers: ☐Yes ☐No Explain: ________________________________________

Serious infections: ☐Yes ☐No Explain: ________________________________________

Surgeries: ☐Yes ☐No Explain: ________________________________________

Broken bones: ☐Yes ☐No Explain: ________________________________________

Asthma: ☐Yes ☐No Explain: ________________________________________

Allergies: ☐Yes ☐No Explain: ________________________________________

Date Last Menstrual Period:☐N/A __________ Pregnancy: ☐Past ☐Present ☐N/A Birth Control: ☐Yes ☐No

| Medical Doctors & Location: | Diagnosis(s): | Medications & Dosages |
|---|---|---|
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |
| ____________________ | ____________________ | ____________________ |

Immunizations Current: ☐Yes ☐No If no, which ones are out of date or needed? ____________________

**Family Health History**

| Mental Health | | Family Member | Medical Health | | Family Member |
|---|---|---|---|---|---|
| Addiction: | ☐Yes ☐No | ______________ | Thyroid disorder: | ☐Yes ☐No | ______________ |
| ADHD: | ☐Yes ☐No | ______________ | Diabetes: | ☐Yes ☐No | ______________ |
| Schizophrenia: | ☐Yes ☐No | ______________ | Cancer: | ☐Yes ☐No | ______________ |
| Mood disorder: | ☐Yes ☐No | ______________ | Heart disease: | ☐Yes ☐No | ______________ |
| Suicide attempt: | ☐Yes ☐No | ______________ | High blood pressure: | ☐Yes ☐No | ______________ |
| Completed suicide: | ☐Yes ☐No | ______________ | Weight/Eating: | ☐Yes ☐No | ______________ |
| Anxiety: | ☐Yes ☐No | ______________ | Bed-wetting: | ☐Yes ☐No | ______________ |
| Panic attacks: | ☐Yes ☐No | ______________ | Seizures: | ☐Yes ☐No | ______________ |
| Tic Disorder: | ☐Yes ☐No | ______________ | | | |
| OCD behavior: | ☐Yes ☐No | ______________ | | | |
| Learning disability: | ☐Yes ☐No | ______________ | | | |
| Abuse: | ☐Yes ☐No | ______________ | | | |
| Legal problems: | ☐Yes ☐No | ______________ | | | |
| Depression: | ☐Yes ☐No | ______________ | | | |

## LEGAL HISTORY

| Present Charges: ☐Yes ☐No | Past Charges: ☐Yes ☐No | Juvenile Detention Center: ☐Yes ☐No |
|---|---|---|
| Please list charge & date: | Please list charge & date: | Please list offenses & dates: |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |

Deputy Juvenile Officer Name: ________________________________________________

Next Court Date: ________________________________________________

**Any additional information you would like us to know:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________