Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

Client Information		
Client's Name:	**Client's DOB:**	**Title 19#:**

If you are completing this for someone else, "you" or "client" refers to the person being seen.

Medications, Supplements
Name / dose / frequency / Time of Day / Start-End Date / Prescribed by / Prescribed for what / better – worse – neutral

Allergies to medications, foods, environment, other
To what / frequency / reaction

Symptoms Experienced
Has the client ever experienced the following?

☐Yes ☐No	Hospitalizations
☐Yes ☐No	Major procedures
☐Yes ☐No	Invasive procedures
☐Yes ☐No	Traumatic Brain Injury, including concussion
☐Yes ☐No	Chronic Pain
☐Yes ☐No	Major acute illness
☐Yes ☐No	Chronic illness
☐Yes ☐No	Significant injuries and/or accidents
☐Yes ☐No	Frequent illnesses

Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

Services Received

Has/is the client, their parents, siblings, or step-family participated/ing in any of the following?

Client	Family	
□Yes ☐No		Annual Physical (or well-child check) within the past year
☐Yes ☐No		Dental Appointment within the past year
☐Yes ☐No		Vision Appointment within the past year
☐Yes ☐No		Hearing Checked within the past year
☐Yes ☐No		Immunizations current
☐Yes ☐No		Lead test current up to age 5 ☐ Not applicable/client 6 or older
☐Yes ☐No	☐Yes ☐No	Day care
☐Yes ☐No	☐Yes ☐No	Preschool
☐Yes ☐No	☐Yes ☐No	Family support/in-home program (Early Head Start, Growing Strong Families, Positive Family)
☐Yes ☐No	☐Yes ☐No	Department of Human Services (DHS)
☐Yes ☐No	☐Yes ☐No	Behavioral Health Intervention Services (BHIS)
☐Yes ☐No	☐Yes ☐No	Early ACCESS from the Area Education Agency (AEA)
☐Yes ☐No	☐Yes ☐No	Individual Education Plan (IEP)/Individual Family Support Plan(IFSP)/ 504 Plan
☐Yes ☐No	☐Yes ☐No	Physical Therapist
☐Yes ☐No	☐Yes ☐No	Occupational Therapist
☐Yes ☐No	☐Yes ☐No	Speech or Feeding Therapist
☐Yes ☐No	☐Yes ☐No	Educational Specialist
☐Yes ☐No	☐Yes ☐No	Psychologist
☐Yes ☐No	☐Yes ☐No	Psychiatrist
☐Yes ☐No	☐Yes ☐No	Mental health therapist/counselor
☐Yes ☐No	☐Yes ☐No	Couples therapist
☐Yes ☐No	☐Yes ☐No	Pastoral counselor
☐Yes ☐No	☐Yes ☐No	Psychiatric inpatient
☐Yes ☐No	☐Yes ☐No	Substance inpatient
☐Yes ☐No	☐Yes ☐No	Drug or alcohol treatment outpatient
☐Yes ☐No	☐Yes ☐No	Gambling treatment
☐Yes ☐No	☐Yes ☐No	Lived in foster care, with a relative, with a friend while growing up
☐Yes ☐No	☐Yes ☐No	Moved 5 or more times while growing up

Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

Personal and Family Health History

Are there any concerns in these areas?

Client	**Family**	
☐Yes ☐No	☐Yes ☐No	Early Milestones (smiling, walking by 18 months, talking by 2 years & understandable by 4 years, enjoy being with others by age 4, etc.)
☐Yes ☐No	☐Yes ☐No	Sleeping (too much, too little, nightmares, night terrors, sleep walking, sleep talking)
☐Yes ☐No	☐Yes ☐No	Eating (including picky eaters)
☐Yes ☐No ☐NA	☐Yes ☐No ☐ NA	Menstruation
☐Yes ☐No	☐Yes ☐No	Joints
☐Yes ☐No	☐Yes ☐No	Cardiovascular (heart)
☐Yes ☐No	☐Yes ☐No	Stroke
☐Yes ☐No	☐Yes ☐No	Diabetes
☐Yes ☐No	☐Yes ☐No	Arthritis
☐Yes ☐No	☐Yes ☐No	Poor circulation
☐Yes ☐No	☐Yes ☐No	High blood pressure
☐Yes ☐No	☐Yes ☐No	Headaches
☐Yes ☐No	☐Yes ☐No	Fainting/Dizziness/Loss of consciousness/Seizures
☐Yes ☐No	☐Yes ☐No	Tics
☐Yes ☐No	☐Yes ☐No	Sexual health
☐Yes ☐No	☐Yes ☐No	Weight
☐Yes ☐No	☐Yes ☐No	Loss of balance
☐Yes ☐No	☐Yes ☐No	Loss of smell or taste
☐Yes ☐No	☐Yes ☐No	Bowel
☐Yes ☐No	☐Yes ☐No	Bladder
☐Yes ☐No	Wetting or soiling once toilet trained. Toilet training	start age ___ end age ___
☐Yes ☐No	Does anyone in the household use tobacco or nicotine products?	

Pregnancy

Circle all that apply to the mother's pregnancy with the client: ☐ No knowledge

full term / pre-term
cesarean / vaginal delivery
complicated / no complication
intended / unintended
alcohol / nicotine / drugs
prenatal care 1st / 2nd / 3rd trimester

Circle all that apply to pregnancies that a female client has had: ☐ Male/NA ☐ None

full term / pre-term
cesarean / vaginal delivery
complicated / no complication
intended / unintended
alcohol / nicotine / drugs
prenatal care 1st / 2nd / 3rd trimester

Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

In your life,

1. Have you seen anything scary?	No	Yes
2. Have you heard anything scary, even if you didn't see it?	No	Yes
3. Experienced the death of someone significant?	No	Yes
4. Experienced a change in caregiver?	No	Yes
5. Has there ever been a time when people gave you a hard time about being too thin or losing too much weight?	No	Yes
6. Have you ever weighed much less than people thought you should weigh?	No	Yes
7. Have you ever gone on eating binges when you ate abnormally large amounts of food over a short period of time?	No	Yes
8. To prevent gaining weight from a binge, would you sometimes force vomit, strict diet, fast, laxative, water pills, enema, exercise?	No	Yes

In the last 12 months,

	Not at all	Several days	More than half the days	Nearly every day
1. Would you say that the atmosphere at home is usually pretty calm?	0	1	2	3

2. Have you become restless, irritable, or anxious when trying to stop/cut down on gambling?	No	Yes
3. Have you tried to keep your family or friends from knowing how much you gambled?	No	Yes
4. Did you have such financial trouble that you had to get help from family or friends?	No	Yes

Southwest Iowa Families, Inc.
215 E. Washington St., Clarinda, IA 51632
Phone: (712) 542-3501 Fax: (712) 542-4725

☐ No romantic or intimate relationship in the past year.

	Disagree Strongly	Disagree Somewhat	Disagree a Little	Agree a Little	Agree Somewhat	Agree Strongly
1. My partner makes me feel unsafe even in my own home.	1	2	3	4	5	6
2. I feel ashamed of the things my partner does to me.	1	2	3	4	5	6
3. I try not to rock the boat because I am afraid of what my partner might do.	1	2	3	4	5	6
4. I feel like I am programmed to react a certain way to my partner	1	2	3	4	5	6
5. I feel like my partner keeps me prisoner.	1	2	3	4	5	6
6. My partner makes me feel like I have no control over my life, no power, no protection.	1	2	3	4	5	6
7. I hide the truth from others because I am afraid not to.	1	2	3	4	5	6
8. I feel owned and controlled by my partner.	1	2	3	4	5	6
9. My partner can scare me without laying a hand on me.	1	2	3	4	5	6
10. My partner has a look that goes straight through me & terrifies me.	1	2	3	4	5	6

11. Has my partner ever physically hurt me? ☐ Yes ☐ No ☐ Not Sure
12. Has my partner ever forced me to do something sexual I didn't want to do? ☐ Yes ☐ No ☐ Not Sure

(For children) How was the child prepared for this visit?

_____

_____

Who disciplines(d) & how?

_____

_____

Is/was there agreement on discipline?

_____

_____