Care Horizon Inc. Child Application for children 12-17
To be completed by MINOR

Name:____ Social Security Number:______________________
First Middle Initial Last

Address:____ County:_____________________
Street City State Zip Code

Phone Number:____ May we leave a message from our office: YES NO
Home Cell
Email address:____ May we contact you via email? YES NO

Birth date:_______________ Age:_______ Gender: ____Male ____Female Race:__________________________

Are you of Hispanic origin: ____YES ____NO If yes, detail:____________ Mother's Maiden Name:____________________

Method of Communication: ______Verbal/Spoken ____Written _____Use Pictures ____Assistive Technology ____TTY

Primary Language: ____English ____Spanish ____American sign language Other:________________

Who do you primarily live with? ____Both Mother and Father ___Mom ___Dad ___Other:__________________________

Who referred you for services_______________________________ Reason for referral: ______________________________

Resources: Are you involved with any self-help groups? ___YES ___NO If yes, please detail:_______________________

Parent/ Guardian _________________________________ _______________ ____________________________
Name Relationship Phone

_________________________________ _______________ _____ ____________________________
Street Address City State Zip Code

Parent/ Guardian _________________________________ _______________ ____________________________
Name Relationship Phone

_________________________________ _______________ _____ ____________________________
Street Address City State Zip Code

Do you have any special needs: ____YES ____NO If yes, detail:______________________________________

Who lives in the house with the you? Check all that apply

___Parent(s)/Guardian(s) of child ___Siblings ___Grandparents ___Other relative(s) ___Non-relative(s) ___Parent's significant other

Where do you live: ___parents home ___foster home ___non-relative's home ___relative's home __group home ___other

What type of home do you live in? ___house ___apartment ___duplex ___mobile home ___other:____________________

Presenting Concern:
What are the problems you feel you need to talk about?

____

____

How has the problem caused problems in your life within the past year?

____

____

Did you just having this problem: ____YES ____NO
If no, for how long have you had problems:____
Do these problems limit you daily: ____YES ____NO

Have you ever:
Had thoughts of hurting yourself? ____YES ____NO
Made a suicide attempt? ____YES ____NO If yes, when:______________________________
Been hospitalized for suicide thoughts/attempts? ____YES ____NO If yes, when:______________________________
Had thoughts of hurting someone else? ___YES ___NO

Are you currently:
Having thoughts of hurting yourself? ____YES ____NO
Having thoughts of hurting someone else? ____YES ____NO
Do you feel you are in danger NOW? ____YES ____NO If yes, please explain:______________________________
Are you involved with a gang? ____YES ____NO
Are you involved in an elder abuse situation? ____YES ____NO
Are you in any other dangerous situation? ____YES ____NO If yes, please explain:____________________
Do you have enough food to eat? ____YES ____NO
Do you believe you need medication? ____YES ____NO
Additional thoughts or comments:____
____

Needs/Preferences:
What are your preferences for treatment based on the services we have available (check all that apply):
____Counseling ____Community support ____Crisis assistance ____Case management ____Family therapy/counseling
____Medication monitoring ____Psychiatric ____Group counseling ____Other: ______________________________

What do you hope you will gain from the services you receive? What is your desired outcome?:
____

Care Horizon Inc. encourages the participation of family or persons in your support system during every phase of treatment. Do you wish to have anyone present during your assessment? ___YES ___NO
If yes, who:____

I am currently requesting services from Care Horizon to resolve these problems and give my consent for treatment. I agree to participate in the Intake, Assessment and Treatment process:

______________________________ ____________________
Signature Date

Ensure completion of medication sheet by self or guardian

FOR CARE HORIZON STAFF USE ONLY:
APPLICATION REVIEWED BY:

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