The Child Guidance Clinic is a community service for children and families and is part of the County Health Department. The services provide early detection, diagnosis and treatment for children and families who have developed behavioral, emotional, social, speech, language, hearing, and intellectual and communication problems; and provides intervention services, which enhance the development of children. Adults or children identified as needing services not available in the Child Guidance Clinic are provided with appropriate referrals. Services will be provided based on the needs of the client and availability of specific staff. Individual cases are reviewed by a team of staff members for thoroughness.

CHILD GUIDANCE CLINICS MAY CONSIST OF THE FOLLOWING SERVICES:

**Parent Education Services:**

Child Development Specialists offer programs which focus on the prevention of developmental and behavioral problems by providing assessment, education and intervention services to parents and young children; administer developmental screenings and assessments to children birth through age eight; provide parent consultation with regard to their child's growth, development and behavior; teach parent study groups to enhance parenting skills and strengthen family interaction. It is not the intent of educational services to remediate or treat mental health and/or behavioral problems in children or adults.

**Psychosocial Services:**

Psychology staff offer services to promote, maintain or restore mental health to children and families in coordination with developmental and physical health services. Psychosocial staff assess, diagnose and treat mental health problems and promote healthy interactions in the prevention of mental disorders.

**Speech, Language, Hearing Services:**

Speech-language pathologists evaluate children's speech and language abilities. Following evaluation, parents are counseled regarding their child's development in the areas of language, articulation, fluency and voice. Hearing acuity is screened and additional tests may be administered to assess the efficiency with which the child is able to understand and use what he hears. If treatment of a problem area is indicated, a variety of methods may be used to help the child improve his skills, including involvement of parents in a home program. Parents are often included in the sessions to encourage positive parent-child interaction and increase language stimulation.

**Screenings:**

A screening is not a complete evaluation. It is a method used to check for possible problems in development, speech, language, hearing, social, emotional and/or behavioral skills. Not passing a screening does not necessarily indicate a disorder, but rather is an indication for referral for more in-depth testing. Due to the limited nature of a screening, certain problems may not be entirely ruled out even if a screening is passed.
**General Information:**

Information is collected as part of the service process for assessment, intervention planning and supervision purposes. Most of the information will be recorded in written form and, as appropriate, some information is recorded on audio and/or videotapes. All information is kept confidential and cannot be released without your written permission. There are, however, special situations under which confidential information could be revealed. These include:

- A "duty to warn" ethic allows a clinician to break confidentiality when danger exists to the client and/or others.
- Under special circumstances, the court may subpoena a client's records and may order a clinician to give testimony during a court hearing.

The fees charged are based on a sliding scale and are determined by the annual gross income and size of your family. No one is refused services because of an inability to pay.

If you cannot come to an appointment or group session, please let the Child Guidance Clinic know at least 24 hours ahead of time.
**CHILD/FAMILY INITIAL CONTACT**

<table>
<thead>
<tr>
<th>Child's Last Name</th>
<th>First Name</th>
<th>Home Phone Number</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Parents</th>
<th>Work Phone #</th>
<th>Person Contacting Guidance &amp; Relationship to Child</th>
</tr>
</thead>
</table>

**Child's Birth Date**

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Race</th>
</tr>
</thead>
</table>

**Reason Seeking Services:**

**Who (Agency or Person) Referred You to the Guidance Clinic?**

**Has Child or Other Family Member Previously Been Seen for Guidance Clinic Services?**

<table>
<thead>
<tr>
<th>Marital Status of Parents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
</tr>
</tbody>
</table>

**Parents' Marital History:**

- Length of Current Marriage
- Any Previous Marriages? (Mother: Yes, No)
- Father: (Yes, No)

**Child is Currently Living With:**

- Natural Parents
- Parent and Step-Parent
- Adoptive Parents
- Single Parent
- In Protective Custody
- Relative
- Other

**List Other Significant Caretakers (Daycare, Babysitters, etc.):**

**Who Has Legal Custody of This Child?**

**Family Information:**

- Number of Times Family Moved in Child's Life?
- Length of Residence in Present Home?

**Has Anyone in the Family Had Psychological, Speech or Hearing Problems?**

**Has Anyone in the Family Had Serious Health Problems?**

**Is This Child Easy to Discipline?**

**How Is This Child Disciplined?**

**Is Any Language Other Than English Spoken in the Home?**

**Are There Any Problems or Changes in Your Family That May Be Affecting This Child?**

**Child's Behavior:**

**Describe Any Problem Behaviors That This Child Exhibits:**

**How Does This Child Get Along with Other Children in the Family?**

**How Does This Child Get Along with Children Outside the Family?**

**What Are Your Child's Strong Points, Assets, or Abilities?**

**Brief Medical History of Child:**

- Major Illnesses Child Has Had:
- Name of Family Physician:
- Date of Last Medical Examinations: __________  __________
- Findings:

**Conditions Presently Being Treated:**

**Medications Presently Being Taken:**

**Please Circle Any Problems This Child Has Had:**

- Seizures
- Serious Injury
- Visual Defect
- Allergies
- Drug Addiction
- Hearing Problem
- High Fever
- Birth Defect
- Speech Problem
- Brain Damage
- Nervous Trouble
- Ear Infections

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Oklahoma State Department of Health
Local Health Services

ODH Form No. 332C
PREVIOUS EVALUATIONS:
HAS THIS CHILD EVER HAD A/AN
A. PSYCHOLOGICAL OR PSYCHIATRIC EXAMINATION? __________________________ DATE: __________________________
   FINDINGS: __________________________
B. SPEECH EXAMINATION? __________________________ DATE: __________________________
   FINDINGS: __________________________
C. VISION AND/OR HEARING EXAMINATION? __________________________ DATE: __________________________
   FINDINGS: __________________________
D. EDUCATIONAL EVALUATION: __________________________ DATE: __________________________
   FINDINGS: __________________________
E. OTHER EXAMINATIONS: __________________________ DATE: __________________________

DEVELOPMENTAL HISTORY:
AT WHAT AGE DID YOUR CHILD
A. SMILE AT PARENTS? __________________________
B. SIT ALONE? __________________________
C. CRAWL? __________________________
D. WALK ALONE? __________________________
ANY CONCERNS ABOUT THIS CHILD'S DEVELOPMENT?

SCHOOL HISTORY:
IF THIS IS A SCHOOL REFERRAL STATE REASON FOR REFERRAL: __________________________
CURRENT SCHOOL: __________________________
IS CHILD CURRENTLY ENROLLED IN A PRE-SCHOOL OR CHILD CARE CENTER?
IF SO, HOW MANY PRE-SCHOOLS OR CHILD CARE CENTERS HAS THIS CHILD ATTENDED?
NUMBER OF SCHOOLS ATTENDED SINCE 1ST GRADe? __________________________
NAME OF CENTER: __________________________
HAS THIS CHILD EVER
A. BEEN PLACED IN A SPECIAL CLASS? __________________________ WHAT KIND?
B. RECEIVED REMEDIAL INSTRUCTION? __________________________ WHAT SUBJECT?
C. REPEATED ANY GRADES? __________________________ WHICH GRADE?
D. RECEIVED TUTORING? __________________________ WHICH SUBJECTS?
E. RECEIVED SPEECH THERAPY? __________________________ WHEN? __________________________ HOW LONG?
F. BEEN TESTED BY SCHOOL COUNSELOR? __________________________ WHEN?
G. BEEN EXPELLED FROM SCHOOL? __________________________ WHEN? __________________________ REASON?
DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SCHOOL PERFORMANCE?

SPEECH, LANGUAGE AND HEARING:
DO YOU HAVE ANY CONCERNS ABOUT THIS CHILD'S SPEECH, LANGUAGE OR HEARING? __________________________

ADDITIONAL INFORMATION:
IS THERE ADDITIONAL INFORMATION WHICH WOULD HELP US TO BETTER UNDERSTAND YOUR CHILD'S/FAMILY'S NEEDS?
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

SIGNATURE OF PERSON COMPLETING APPLICATION
### FAMILY HISTORY
List relatives (mother, father, brothers, sisters, aunts, uncles, grandparents) who have or have had any conditions.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>YES</th>
<th>CONDITION</th>
<th>YES</th>
<th>CONDITION</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy to Medication, Food, Pollen, Etc.</td>
<td>Drug/Alcohol Abuse</td>
<td>Physical Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia/Sickle Cell Trait</td>
<td>Heart Disease</td>
<td>Rheumatic Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis/Joint Disease</td>
<td>High Blood Pressure</td>
<td>Sexual Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma, Emphysema</td>
<td>Kidney/Urine Tract Disease</td>
<td>Thymus, Other Lung Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Defects</td>
<td>Mental Retardation</td>
<td>Thyroid Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Disease</td>
<td>Muscle/Bone Disease</td>
<td>Venereal Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer: Specify</td>
<td>Nerve Disorder: Epilepsy, Cerebral Palsy, Etc.</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diabetes**

**Does either parent or person caring for the child have any serious or continuing health problems?** [ ] Yes [ ] No

### MOTHER'S PREGNATAL HISTORY
Check or give answer to each question.

**Number of Pregnancies?**

<table>
<thead>
<tr>
<th>DATE OF PREVIOUS PREGNANCY</th>
<th>HOW MANY LIVING CHILDREN DO YOU HAVE?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ] No [ ] Yes</td>
</tr>
</tbody>
</table>

**Was this a planned pregnancy?** [ ] Yes [ ] No

**Did you receive prenatal care during your pregnancy?** [ ] Yes [ ] No

**Number of visits for care?** 0-3 [ ] Yes 4-9 [ ] No [ ] 10 or more

**Did any of the following occur while you were pregnant?**

- Urinary Tract Infection
- Accidents
- Swelling of Hands or Face
- Other Infections
- Other (Specify)

**Did you have any health problems before this pregnancy?** [ ] Yes [ ] No

**Did you receive any medication or anesthetic during labor?** [ ] Yes [ ] No

**Where was the baby born?** [ ] Home [ ] Other (Specify)

**Who delivered the baby?** [ ] Doctor [ ] Midwife (Specify)

**How many hours were you in labor?**

**What type of delivery?** [ ] Cesarean Section [ ] Breech [ ] Normal

**Did you receive any medication or anesthesia during labor?** [ ] Yes [ ] No

**Comments:** [ ] Yes [ ] No

**Were there any complications during labor and delivery?** [ ] Yes [ ] No

**How old were you when this baby was born?** [ ] Yes [ ] No

**Was this a multiple birth (twin, triplet)?** [ ] Yes [ ] No

**Was the baby born more than 2 weeks early or late?** [ ] Yes [ ] No

**When did you first hold the baby?** [ ] Yes [ ] No

**How much did the baby weigh?** [ ] Yes [ ] No

**Did the baby have any problems?**

- Breathing
- Color
- Other

**Did the baby have an I.V. or oxygen?** [ ] Yes [ ] No

**Was the baby in an incubator?** [ ] Yes [ ] No

**Was a PKU or T4 done on the baby?** [ ] Yes [ ] No

### PAST MEDICAL HISTORY
Has your child ever had any of the following problems? If so, please give age.

- Allergic Rhinitis
- Constipation
- Anemia
- Convulsions
- Asthma
- Diarrhea
- Ear Problems
- Cancer
- Chickenpox

**Hospitalizations**

**Does your child seem to be developing normally?** [ ] Yes [ ] No

**Does your child hear well?** [ ] Yes [ ] No

**Does his/her voice sound normal?** [ ] Yes [ ] No

**Has your child had any reactions following previous immunizations?** [ ] Yes [ ] No

**Has your child ever received any immune globulin (IG, TIG, HBG, etc)?** [ ] Yes [ ] No

**Has your child had any other medical problems, surgeries, or serious diseases?** [ ] Yes [ ] No

**Do you have any concerns about your child?** [ ] Yes [ ] No

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Oklahoma State Department of Health
Child and Adolescent Health

Reviewer's Signature: __________________________ Date: ____________