Child's Last Name: _______________

Child Name: ____

____

FAMILY HOUSE, INC.

ORIENTATION SHEET

Date: ________________________

O **Visiting Party** O **Custodial Party** **Relationship to the Child(ren):** ________________

Current DCS Involvement? O YES O NO IF yes, DCS case number: ______________________

PERSONAL INFORMATION

Name: ______________________________________ Date of Birth: ________________ Age: ___

Address: ____

City: ______________________________ State: _____ Zip: ___________ County: ___________

Email Address: ____

Phone #: ____

Emergency Contact Name/Relationship to you: ____

Age of Emergency Contact: _______________ Phone #: ___________________________________

May this person pick the children up in an emergency? O YES O NO

Race/Ethnicity (please circle)

African American	Asian/Pacific Islander	Caucasian
Hispanic/Latino	Native American/Alaska Native	More than one race

Primary language spoken in the home and/or with the children that will be visiting? ___________

Any difficulties reading, speaking, or understanding English? ______________________________

Are you currently receiving counseling services? ___________ If yes, where/with whom?

____

Child's Last Name: _______________

Child Name: ____

____

Do you have a disability? (Circle all that apply)

None	Intellectual Disability	Deaf	Mute	Illiterate
Other physical/mental	Neuralgic Impairment	Non-Ambulatory (wheelchair bound)	Other describe:	

Living Arrangements:

Rent	Own	Residential Facility
Live with Parents	Homeless	

Marital Status: ________________

Highest Education Completed:

Current Student	Elementary (K-5)	Middle (6-8)	HS Graduate (or equivalent)	1 yr college
2 yr/ Associate Degree	College Graduate	Master's Degree	Doctorate Degree	Trade School

Employment Status:

Full time	Part time (<34hrs/week)	Unemployed-looking for work
Retired	Disabled	Other describe:

Who resides with you? (Include all adults and children)

____

____

____

Please provide a short description of what brings you to Family House:

____

____

____

____

____

Do you have a support system? If so, who?

____

____

____

Child's Last Name: _______________

Child Name: ____

____

Do you participate in social gatherings?

____

____

Describe your relationship with your child(ren).

____

____

____

____

What type of discipline do you find to be the most effective with your child(ren)?

____

____

____

Describe your relationship with you child(ren)'s mother or father.

____

____

____

____

Are you currently involved in an intimate relationship? O **YES** O **NO**

IF yes, do you feel safe in this relationship? **O YES** O **NO** O **Not Applicable**

Legal History: ____ Arrests _____Incarcerations _____Probation _____Other Violations

Explain:____

____

____

____

Have you ever been involved in a gang? O **YES** O **NO**

Explain:____

____

____

Child's Last Name: _______________

Child Name: ____

____

Have you now or ever been involved with the Department of Child Services (DCS)?

O **YES** O **NO** If **yes**, please describe reason for services.

____

____

____

____

____

Have you now or ever had an Order of Protection put in place? O **YES** O **NO** If **yes**, describe the Order of Protection. (Please provide a copy to Family House)

____

____

____

____

Are you concerned that someone you know may try to take you child(ren)without you consent? O **YES** O **NO** If yes, explain.

____

____

____

Medical History:

Current or chronic medical concerns:

____

____

____

How do you feel today?____

Is this typical?

____

Have you noticed any of the following in the past 6 months? **(Circle all that apply)**

Changes in sleep patterns	Changes in weight/appetite	Difficulty concentrating
Reduction in energy level	Reduction in pleasurable activities	Feelings of helplessness/hopelessness

Explain:

____

____

____

Child's Last Name: _______________

Child Name: ____

____

Do you have an emergency treatment plan put in place for you condition? If so, describe.

____

____

____

Do you currently use alcohol or drugs? If so, please include frequency.

____

____

Have you ever been involved in alcohol or drug treatment? O **YES** O **NO** If **yes**, explain.

____

____

____

Have you ever had any psychiatric hospitalizations? O **YES** O **NO**

If yes Where? _________________________________ When? ___________________________________

Outcome? ____

Have you ever had any outpatient treatment? O **YES** O **NO**

If yes Where? _________________________________ When? ___________________________________

Outcome? ____

Family History of Mental Health Issues:

____

____

____

____

Mental Health Other:

____

____

____

What expectation do you have to receive from Family House services?

____

____

____

____

Child's Last Name: _______________

Child Name: ____

____

VISIT LOCATION

Where will the visit take place? O **Family House** O **Off-site**

Indicate the type of dwelling in which you reside. (please circle)

House	Apartment	Condo	Mobile Home	Other:

Do you have any pets? O **YES** O **NO** If yes, how many____________________

Please note weather pet has a history of showing aggressive behavior and/or has a disease that is transferable to humans.

____

____

Do you have weapons in you home? O **YES** O **NO** If yes, how many____________________

Describe. ____

Describe your experience of safety within you community.

____

____

____

VEHICLE INFORMATION

Vehicle Year: ______________ Make/Model: ___________________

Color: ______________ License Plate #: ____________________

FINANCIAL INFORMATION

Annual Income (please circle one)

$0-$9.999	$10,000-$19,999	$20,000-$29,999	$30,000-$39,999	$40,000 and up

Employer Name:

____

Child's Last Name: ______________

Child Name: ____

____

CHILD(REN) INFORMATION

(Complete section for each child that will be visiting Family House)

(1)Child's Name: ____

Date of Birth: ______________________________________ Age: ___________________

Child's Gender: O Male O Female

Race/Ethnicity (please circle)

African American	Asian/Pacific Islander	Caucasian
Hispanic/Latino	Native American/Alaska Native	More than one race

Please list any allergies to food or medication and the reaction.

____
____
____

Note any chronic medical condition and emergency treatment plan.

____
____
____

Note any emotional or behavioral concerns and any coping strategies that help your child.

____
____
____

(2)Child's Name: ____

Date of Birth: ______________________________________ Age: ___________________

Child's Gender: O Male O Female

Race/Ethnicity (please circle)

African American	Asian/Pacific Islander	Caucasian
Hispanic/Latino	Native American/Alaska Native	More than one race

Child's Last Name: _______________

Child Name: ____

____

Please list any allergies to food or medication and the reaction.

____

____

____

Note any chronic medical condition and emergency treatment plan.

____

____

____

Note any emotional or behavioral concerns and any coping strategies that help your child.

____

____

____

(3)Child's Name: ____

Date of Birth: _____________________________________ Age: ___________________

Child's Gender: O Male O Female

Race/Ethnicity (please circle)

African American	Asian/Pacific Islander	Caucasian
Hispanic/Latino	Native American/Alaska Native	More than one race

Please list any allergies to food or medication and the reaction.

____

____

____

Note any chronic medical condition and emergency treatment plan.

____

____

____

Note any emotional or behavioral concerns and any coping strategies that help your child.

____

____

____

Child's Last Name: _______________

Child Name: ____

____

- - - -- - Office use only- - - - - - -

IF Court Order what type: Individual therapy—TSV—SV—Exchanges

If DCS, what type: Individual therapy—TSV—SV—Exchanges

Visits per week : _________________

Length of visits: _________________

Which party pays: _______________

If split percentage: ______________

Client Restrictions:

Pictures ____Yes ____No

Gifts ____Yes ____No

Outside play ____Yes ____No

Snacks/food ____Yes ____No

Visitors ___ Yes ____ No

Visitors if approved names:

____

____

____

______ Copy of FH Policy has been given

______ Completed report

______ Restriction given/reviewed

CO rcvd date ________________________