Family Unification Support Services, Inc.

CLIENT FACE SHEET

Client Name: ____

Physician Name: ____

Date: ________________

Medication Information (include dosage, method of administration / directions for any medication needed by the client):

____

____

____

____

List any allergies:

____

____

____

Name and telephone number of emergency contact:

____

Name and telephone number of case manager:

____

Family Unification Support Services, Inc.

ADULT CLIENT INFORMATION

Please provide the information requested below. Information will be kept confidential.

1. Briefly describe reason for seeking help at this particular time: ____

   How will you know when this situation/problem has been improved? ____

2. Have you experienced any recent losses or deaths? ☐ NO ☐ YES: ____

3. Describe any major accidents or injuries: ☐ NONE ☐ YES: ____

4. Describe any significant current medical condition(s). Note allergies, medications and/or sleeping:
   ☐ NONE ☐ YES: ____

5. Family Configuration: ☐ M/F ☐ Single Mother ☐Single Father ☐Blended ☐Children in Foster Care

6. Has anyone in your family had mental health treatment (hospitalization)? ☐ NO ☐YES:

Name of Client:	Name of Therapist:	Length of Treatment:

Was treatment helpful: ☐YES ☐NO

7. Any history of drug/alcohol abuse in family? ☐ NO ☐ YES: ____

8. List all your current medications: prescription (including birth control pills) and non-prescription (aspirin, ibuprofen, allergy medication, vitamins, etc.)

Medication	Dosage	Prescribed for

9. Your Physician: ____________________________ Date of last exam: ____/____/____

10. Significant legal history: ☐ NONE ☐ YES: ____

11. Ethnic background of family: ☐ Am. Indian ☐ African Am. ☐Hispanic ☐Caucasian ☐Asian ☐Other: ______________________ Do you have the need for an interpreter?: ☐ NO ☐ YES: ____________________________

12. Please provide any additional information that you feel is important: ____

______________________	______________________	______________________
Participant (Please Print Name)	**Signature**	**Date**

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FAMILY DEMOGRAPHIC INFORMATION

Client Name: ____________________________ Date of Interview: ______________________

Address: ____________________________ Phone Number: ______________________

Nickname (if any): ____________________________ Interviewer: ______________________

Age/Ethnicity: ____________________________ Agency: ______________________

Case Manager: ____________________________ Guardian ______________________

Probation Officer: ____________________________ Staff Name/Credential: ______________________

This document will assist Family Unification Support Services, Inc. in placement consideration and serve as an initial profile of the client to assist staff in the first few days of integration. Please answer all questions and be assured that all information will be regarded as confidential.

Medical / Physical: Please circle all that apply. Comment on back as necessary.

Prescription medication, allergies, gasses, chronic conditions, ear infections, stomach aches, toothaches, rashes, constipation, menses, headaches, other: ____

Self Care: Please circle the items that require assistance / monitoring:

Bathing Brushing teeth Dressing Eating Outings Crowds

Behavioral: Please circle and explain in back behavioral considerations necessary for direct are workers. Please be direct. The information will not automatically disqualify placement, but will assist us in structuring the environment to best meet your needs.

Hits others curses spits kicks/scratches screams lies withdraws self-abuse
Inappropriately disrobes leaves house unauthorized breaths things hides things cries
frequently ignores staff

List consequences used in the past that were both effective and ineffective as well as any other pertinent comments: ______________________________

____

____

____

Family Unification Support Services, Inc.

STEPS TO BECOMING A MENTOR

- **COMPLETE AN INTERVIEW**
- **COMPLETE FINGERPRINT / BACKGROUND CHECK**
- **SIGN AUTHORIZATION FOR SECURE SEARCH / DRIVER RECORD AND ADDITIONAL BACKGROUND CHECK / SS VERIFICATION**
- **COMPLETE DRUG TESTING AT LABCORP**
- **ATTEND MENTOR TRAINING**