CLIENT INFORMATION - FACE SHEET

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Demographics

First Name: _____ **MI:** _____ **Last Name:** _____

Address: _____
(Street) (City) (State) (Zip) (County)

Caregiver: _____ **Relationship to Client:** _____

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Work Phone:** (_____)_____

Email Address (Parent/Guardian): _____

Default Method of Contact ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Client's Date of Birth: _____ / _____ /_____ **Sex Assigned at Birth:** ☐ Male ☐ Female **Pronouns:** _____

Race: ☐ White ☐ African American ☐ Asian ☐ Bi-Racial ☐ Hispanic ☐ Native American ☐ Pacific Islander ☐ African

Household Type: ☐ Single Parent Household ☐ Two Parent Household ☐ Multi-Family ☐ Self

Total Adults in Household: _____ **Total Dependents Under 18:** _____ **Total Dependents Over 18:** _____

Estimated Household Income: $_____

Primary Care Physician: _____ **Office Location:** _____

School Attending: _____ **Grade:** _____

Diagnosis: _____

Service History: ☐ Individual therapy ☐ Family therapy ☐ Group therapy ☐ BHIS ☐ PIH ☐ Hospitalization ☐ Mentoring

Individual Financially Responsible for Account ☐ is legal Guardian

Name: _____ **Relationship to Client:** _____ ☐ **Same Info. Above**

Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Email:**_____

Emergency Contact Information ☐ is legal Guardian

Name: _____ **Relationship to Client:** _____ ☐ **Same Info. Above**

Address: _____
(Street) (City) (State) (Zip) (County)

Home Phone: (_____)_____ **Cell Phone:** (_____)_____ **Email:**_____

Insurance Information ☐ has Medicare

Primary
Insurance Company: _____
Insurance ID:_____ Group#_____
Co-Pay Amt. $_____ Co-Insurance %_____
Relationship to Insured: ☐ Child ☐ Spouse ☐ Self ☐ Other
Subscriber information:
Name: _____
DOB: _____/_____/_____ Gender: ☐ Male ☐ Female
Address: _____
Phone #: (_____) _____
Employer:_____

Secondary (if applicable)
Insurance Company: _____
Insurance ID: _____ Group#_____
Co-Pay Amt. $_____ Co-Insurance %_____
Relationship to Insured: ☐ Child ☐ Spouse ☐ Self ☐ Other
Subscriber information:
Name: _____
DOB: _____/_____/_____ Gender: ☐ Male ☐ Female
Address: _____
Phone #: (_____) _____
Employer:_____

Add any additional contacts on the back of sheet

INFORMED CONSENT AND ACKNOWLEDGEMENT

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Name: _____ DOB: _____

Please initial next to each item below to indicate your understanding and/or to indicate you received the document(s) mentioned.

_____ **Informed Consent**: I have chosen to receive treatment through Tanager Place. I understand that I may terminate treatment at any time. I understand that treatment is cooperative and that I have the right to be fully informed regarding the benefits or potential problems associated with any treatment I receive. I understand that treatment may be delivered in varying settings and that I will be informed of such setting by the assigned therapist.

I understand that information collected about me shall be confidential unless a release of information is given. Any release of information is only valid for the time period indicated and may be rescinded at any time. Exceptions will apply only in circumstances that legally require sharing information.

_____ **Group Therapy (as applicable):** I have chosen to participate in group therapy. I understand that other children and a Tanager Place clinician will be involved in these sessions.

Date: _____ **Printed Name:** _____
(Patient or Authorized Representative)

Witness: _____ **Signature:** _____
***(Patient or Authorized Representative)

_____
(Relationship if other than Client)

***** *Must be signed by client if 18 or over*

1030 5th Ave SE | Cedar Rapids, IA 52403
P: (319) 286-4545 F: (319) 368-3358

2309 C St SW | Cedar Rapids, IA 52404
P: (319) 365-9164 F: (319) 365-6411

1150 5th St, Suite 160 | Coralville, IA
P: (319) 286-4520

ACKNOWLEDGEMENT

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Name: _____ DOB: _____

Please initial next to each item below to indicate your understanding and/or to indicate you received the document(s) mentioned.

_____ **Duty to Warn:** I understand that it is the responsibility of my provider to report if a client or other identifiable person is in clear or imminent danger. If my provider believes that the client is a threat of harm to themselves, or someone else, it is their duty to report that threat to the authorities.

In situations where there is clear evidence of danger to the client or other persons, the provider must determine the degree of seriousness of the threat and notify the person in danger and others who are in a position to protect that person from harm.

_____ **Mandatory Reporting:** I understand that my provider is a mandatory reporter; therefore it is their obligation to make a report to the Department of Human Services if they become aware of **suspected** child abuse. This can include, but is not limited to, sexual abuse, physical abuse, mental injury, neglect and witness to domestic violence. The clinician is not responsible for investigating or authenticating any allegations and it is not their role to determine if the reported abuse meets qualification for reception of an investigation by the Department of Human Services.

_____ **I** understand that my provider is responsible for providing information to the Iowa Foster Care Review Board, as outlined in **Iowa Code 237.21** for any child receiving treatment while in foster placement**.**

Notice of Privacy Practices provides information about how we may use and disclose protected health information about you or your child. I understand that Tanager Place has the right to change this Notice at any time. I may obtain a current copy by contacting Tanager Place directly or through their website. By initialing below you are acknowledging that Tanager Place has made our Notice of Privacy Practices available to you for review and

Copy was provided _____ Or Declined Copy _____

_____ I hereby acknowledge that I have received a copy of Tanager Place's **Client Handbook**

Date: _____ **Printed Name:** _____
(Patient or Authorized Representative)

Witness: _____ **Signature:** _____
***(Patient or Authorized Representative)**

_____
(Relationship if other than Client)

***** *Must be signed by client if 18 or over*

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TELETHERAPY INFORMED CONSENT

Client Name: _____ DOB: _____
Medicaid ID:_____

Teletherapy is the means of delivering therapy services over the internet through the use of video conferencing. Please initial next to each item below to indicate your understanding and informed consent to receive therapy services via teletherapy.

_____ **Risk of Harm**: Teletherapy may not be appropriate for all clients. I understand that Tanager Place therapists will conduct a Mental Health Assessment, and will maintain regular monitoring of symptoms to determine appropriateness for this service delivery option. I understand that teletherapy is not a crisis based clinical service.

_____ **Technology**: Tanager Place utilizes a HIPAA compliant video service to conduct teletherapy sessions. I understand that I am responsible for securing my own electronic device/computer, internet access point, and password security. Tanager Place is not responsible for my equipment failure and/or internet service/connection. Tanager Place is not responsible for lapses in confidentiality that are in direct response to my actions.

_____ **Internet Connectivity**: I understand that disconnections may occur. I understand that if I am using a phone or tablet, that connecting to Wi-Fi may improve the video quality of the session. Tech Troubleshooting is available through the HIPAA compliant video service utilized to conduct sessions.

If disconnection occurs or if video services are not available at the time of or during my session, I understand that my clinical provider will attempt to restart the session. If the session is not able to restart, my clinical provider will call me to reschedule the appointment.

_____ **Recordings:** I understand that audio and/or video recording of teletherapy sessions are prohibited without the written consent of both the client and clinical provider.

_____ **Confidentiality Restrictions:** I understand that the laws that protect the confidentiality of any medical information also apply to online therapy including limitations such as Duty to Warn and Mandatory Reporting outlined in Tanager Place's Acknowledgement.

Date: _____ **Printed Name:** _____
(Patient or Authorized Representative)

Witness: _____ **Signature:** _____
(Patient or Authorized Representative)

_____
(Relationship if other than Client)

AUTHORIZATION TO EXCHANGE ePHI

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Name: _____ DOB: _____

Please indicate next to each item below your desire to communicate electronically via email and/or text message with your Tanager Place Staff.

Authorization for email communication

_____ I authorize the Tanager Place Staff to email me regarding the course of my medical care, treatment and diagnostic test results, including information concerning mental health, substance abuse and sexually transmitted disease.

_____ I authorize Tanager Place Billing and Patient Accounts to email me with questions regarding my account status.

Patient/representative's email address (*please print*): _____

Authorization for text communication

_____ I authorize the Tanager Place Staff to text me regarding the course of my medical care, treatment and diagnostic test results, including information concerning mental health, substance abuse and sexually transmitted disease.

Patient/representative's phone number (*please print*): _____ _____

- I understand that any electronic transmission between my provider and me/the patient will become part of my medical record. These email transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this Authorization at any time by indicating so below. If I want to revoke this authorization, I must do so in writing. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
- I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, membership or eligibility for Tanager Place benefits if I refuse to sign this Authorization.
- I understand that, once information is disclosed pursuant to this Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

AUTHORIZATION TO EXCHANGE ePHI

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Name: _____ DOB: _____

Alert for Electronic Communication
Patients and/or personal representatives who want to communicate with their health care providers via electronic means should consider all of the following issues before signing an Authorization to exchange Protected Health Information electronically:

Electronic communication can be forwarded, intercepted, printed and stored by others.

1. Electronic communication is a convenience and is not appropriate for emergencies or time-sensitive issues**.**
2. Highly sensitive or personal information should only be communicated electronically at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
3. Employers generally have the right to access any email received or sent by a person at work.
4. Staff other than the health care provider may read and process email.
5. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
6. Communication guidelines must be defined between the clinician and the patient, including (1) how often email will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for email.
7. Email message content must include (1) the subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and (2) clear patient identification including patient name, telephone number and date of birth or patient identification number (if known) in the body of the message.
8. Tanager Place will not be liable for information lost or misdirected due to technical errors or failures.

I have read and understand the Alert for Electronic Communications and agree that email messages and/or text exchanges may include protected health information about me / the patient, whenever necessary.

Date: _____ **Printed Name:** _____
(Patient or Authorized Representative)

Witness: _____ **Signature:** _____
(Patient or Authorized Representative)

_____
(Relationship if other than Client)

**Please note that this Authorization is not valid unless completed in full.*
This Authorization will not expire unless revoked in writing below

Discontinue electronic communication

_____ I no longer wish to communicate via email. Date revoked: _____

_____ I no longer wish to communicate via text. Date revoked: _____

1030 5th Ave SE | Cedar Rapids, IA 52403
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P: (319) 365-9164 F: (319) 365-6411

1150 5th St, Suite 160 | Coralville, IA
P: (319) 286-4520

CONSENT TO RELEASE AND EXCHANGE INFORMATION

TANAGER PLACE
YOUR CHILD : OUR FOCUS

CLIENT NAME:_____ DOB: _____

SCHOOL DISTRICT

I hereby voluntarily authorize Tanager Place to disclose information to/from:

_____
Name of Person / Organization

_____
Address

_____
Phone / Fax Number

PURPOSE: _____

☐ Treatment ☐ Personal Use

☐ Insurance or Legal ☐ Other: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorize the exchange and release of confidential information to or from the above individual(s) and/or organization. The information exchange may be in oral or written form. I understand that my authorization will remain effective from the date of my signature until _____ (MM/DD/YY), and that information will be handled confidentially in compliance with all applicable federal laws.

The purpose of this exchange of information is to ensure that pertinent information is available to Tanager Place staff for provision of the most comprehensive treatment possible. Services rendered, however, are not contingent upon the receipt or exchange of this information. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services.

I understand that I may review the disclosed information at the discretion of the sending person, institution or organization. I understand I can revoke my consent by writing to all concerned parties involved in the information exchange. However, any information already exchanged may be used as stated in this consent. Disclosure of this information carries with it the potential for unauthorized re-disclosure and once information is disclosed it may no longer be protected by federal privacy regulations.

I authorize the release of confidential information which requires specific consent under federal law.

Type of information: (Indicate Yes or No for all)

Mental Health*	☐ Yes	☐ No
Substance Abuse **	☐ Yes	☐ No
HIV / AIDS related Info.	☐ Yes	☐ No

Information to be released – from _____ to _____

☐ History and Physical ☐ Treatment Plan ☐ Reviews
☐ Progress Note(s) ☐ Lab / Pathology ☐ Consultations
☐ Immunization Record ☐ Discharge Summary ☐ Psychological Report
☐ Other: _____

Date: ____ /_____/_____

Printed Name: _____
(Patient or Authorized Representative)

Witness: _____

Signature: _____
(Patient or Authorized Representative)

_____
(Relationship if other than Client)

* Only a person 18 years of age or older or a person's legal representative can authorize release of mental health information.
** Only the subject can authorize release of substance abuse information unless the subject is of such age and mental maturity that they are unable to authorize release.

COPY OF CONSENT GIVEN TO PARENT/GUARDIAN AND CLIENT_____ **OR DECLINED COPY** _____

- **OVER** -

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Notice to Recipients of Mental Health Information In accordance with "Disclosure of Mental Health and Psychological Information" (Iowa Code, Chapter 228), a recipient of mental health information may further disclose this information only with the written authorization of the subject or the subject's legal representative or as otherwise provided in Chapters 228 and 229. Unauthorized disclosure is unlawful and civil damages and criminal penalties may apply. Federal confidentiality rules (42 CFR Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of Substance Abuse Information This information has been disclosed from records whose confidentiality is protected by federal law. Iowa Code, Chapter 125 and federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written authorization of the person to whom the information pertains, or as otherwise permitted by such statute and regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice to Recipients of HIV-Related Testing Information This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. (Iowa Code Section 141A.9) Federal confidentiality rules (42 CFR, Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

CONSENT TO RELEASE AND EXCHANGE INFORMATION

TANAGER PLACE
YOUR CHILD : OUR FOCUS

CLIENT NAME:_____ DOB: _____

LEARNING SUPPORTS TEAM

I hereby voluntarily authorize Tanager Place to disclose information to/from:

_____
Name of Person / Organization

_____
Address

_____
Phone / Fax Number

PURPOSE: _____

☐ Treatment ☐ Personal Use

☐ Insurance or Legal ☐ Other: _____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

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Mental Health*	☐ Yes	☐ No
Substance Abuse **	☐ Yes	☐ No
HIV / AIDS related Info.	☐ Yes	☐ No

Information to be released – from _____ to _____

☐ History and Physical ☐ Treatment Plan ☐ Reviews
☐ Progress Note(s) ☐ Lab / Pathology ☐ Consultations
☐ Immunization Record ☐ Discharge Summary ☐ Psychological Report
☐ Other: _____

Date: ____ /_____/_____

Printed Name: _____
(Patient or Authorized Representative)

Witness: _____

Signature: _____
(Patient or Authorized Representative)

_____
(Relationship if other than Client)

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CONSENT TO RELEASE AND EXCHANGE INFORMATION

TANAGER PLACE
YOUR CHILD : OUR FOCUS

CLIENT NAME:_____ DOB: _____

PRIMARY CARE PHYSICIAN

I hereby voluntarily authorize Tanager Place to disclose information to/from:

_____
Name of Person / Organization

_____
Address

_____
Phone / Fax Number

PURPOSE: _____

☐ Treatment ☐ Personal Use

☐ Insurance or Legal ☐ Other: _____

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☐ Other: _____

Date: ____ /_____/_____

Printed Name: _____
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Witness: _____

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CONSENT TO RELEASE AND EXCHANGE INFORMATION

TANAGER PLACE
YOUR CHILD : OUR FOCUS

CLIENT NAME:_____ DOB: _____

I hereby voluntarily authorize Tanager Place to disclose information to/from:

_____
Name of Person / Organization

_____
Address

_____
Phone / Fax Number

PURPOSE:

☐ Treatment ☐ Personal Use

☐ Insurance or Legal ☐ Other: _____

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☐ History and Physical ☐ Treatment Plan ☐ Reviews
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☐ Other: _____

Date: ____ /_____/_____

Printed Name: _____
(Patient or Authorized Representative)

Witness: _____

Signature: _____
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Save Form

CURRENT SYMPTOM CHECKLIST

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Name: _____ **DOB:** _____

INSTRUCTIONS: *INDICATE PRESENCE OF EACH PROBLEM OR SYMPTOM, WITH LEVEL OF OCCURRENCES FROM NEVER TO ALWAYS*

	Never/NA	Rarely	Sometimes	Often	Always
Physical Aggression	◉	○	○	○	○
Verbal Aggression	◉	○	○	○	○
Destruction of property	◉	○	○	○	○
Agitation	◉	○	○	○	○
Argues	◉	○	○	○	○
Fights with others	◉	○	○	○	○
Quick to anger	◉	○	○	○	○
Meltdowns	◉	○	○	○	○
Avoidant	◉	○	○	○	○
Cruelty towards animals	◉	○	○	○	○
Non-compliant	◉	○	○	○	○
Fire Setting	◉	○	○	○	○
Runs away	◉	○	○	○	○
Lying	◉	○	○	○	○
Absent from school	◉	○	○	○	○
Takes unnecessary risks	◉	○	○	○	○
Sexualized behavior	◉	○	○	○	○
Regressive Behaviors	◉	○	○	○	○
Difficulty with change	◉	○	○	○	○
Difficulty coping	◉	○	○	○	○
Indiscriminate affection with strangers and others	◉	○	○	○	○
Clingy with parent	◉	○	○	○	○
Difficulty with parental absence	◉	○	○	○	○
Does not go to parent for comfort	◉	○	○	○	○
Will not accept closeness or comfort	◉	○	○	○	○
Acute jealousy towards siblings	◉	○	○	○	○
Bossy toward others	◉	○	○	○	○
Teases others	◉	○	○	○	○
Is down on him or herself	◉	○	○	○	○
Acts younger than children his or her age	◉	○	○	○	○
Does not show feelings	◉	○	○	○	○
Does not understand other people's feelings	◉	○	○	○	○
Blames others for his or her troubles	◉	○	○	○	○
Difficulties with peers	◉	○	○	○	○
Frequent visits to the Dr.	◉	○	○	○	○
Flashbacks	◉	○	○	○	○
Weight concerns	◉	○	○	○	○
Body image distortion	◉	○	○	○	○
Negative Self Talk	◉	○	○	○	○
Negative view of self	◉	○	○	○	○
Nutritional concerns	◉	○	○	○	○
Nightmares	◉	○	○	○	○
Difficulty falling asleep	◉	○	○	○	○
Difficulty staying asleep	◉	○	○	○	○
Oversleeping	◉	○	○	○	○

Continued…	Never	Rarely	Sometimes	Often	Always
Lack of sleep	○	○	○	○	○
Obsessions	○	○	○	○	○
Compulsions	○	○	○	○	○
Hoarding behaviors	○	○	○	○	○
Afraid of new situations	○	○	○	○	○
Excessive fears	○	○	○	○	○
Racing Thoughts	○	○	○	○	○
Reactive	○	○	○	○	○
Restless	○	○	○	○	○
Rigidity	○	○	○	○	○
Tense	○	○	○	○	○
Nervous	○	○	○	○	○
Worries excessively	○	○	○	○	○
Tics	○	○	○	○	○
Tremors	○	○	○	○	○
Concentration problems	○	○	○	○	○
Fails to complete tasks	○	○	○	○	○
Fidgety	○	○	○	○	○
Low frustration tolerance	○	○	○	○	○
Hyperactive	○	○	○	○	○
Impulsive	○	○	○	○	○
Irritable	○	○	○	○	○
Procrastinates	○	○	○	○	○
Crying Spells	○	○	○	○	○
Prolonged sadness	○	○	○	○	○
Helpless	○	○	○	○	○
Hopeless	○	○	○	○	○
Isolated	○	○	○	○	○
Withdrawn	○	○	○	○	○
Loss of energy	○	○	○	○	○
Loss of interest	○	○	○	○	○
Complains of aches and pains	○	○	○	○	○
Mood swings	○	○	○	○	○
Tires easily	○	○	○	○	○
Delusions	○	○	○	○	○
Hallucinations	○	○	○	○	○
Grandiose thinking	○	○	○	○	○
Paranoia	○	○	○	○	○
Enuresis (wetting accidents)	○	○	○	○	○
Encopresis (soiling accidents)	○	○	○	○	○
Other abnormal bathroom behaviors	○	○	○	○	○
Alcohol	○	○	○	○	○
Drug	○	○	○	○	○
Prescription pill abuse	○	○	○	○	○
Gambling	○	○	○	○	○
Nicotine	○	○	○	○	○
Technology	○	○	○	○	○
Non Suicidal Self Injury (NSSI)	○	○	○	○	○
Suicidal	○	○	○	○	○
Homicidal	○	○	○	○	○

CLIENT ASSESSMENT INFORMATION

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Name: _____ DOB: _____

What brings you to Tanager Place? What is the current presenting mental health problem(s)?

What are you or your child's goals for treatment?

Does your child have a history of mental health needs? If yes, please include current or past diagnoses, previous treatment, hospitalizations, providers, etc.

Were there any complications during pregnancy or childbirth for your child? If so, please explain.

Was your child delayed with any developmental milestones? Have they had any attachment or separation concerns? If yes, please explain.

CLIENT ASSESSMENT INFORMATION

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Please provide us with family history information such as family members, living arrangements, placement history, etc.

Please tell us about your child's social relationships and supports such as friends, support system, significant others, etc.

Please provide us with any educational or vocational history for your child such as special needs, IEP, work history, etc.

Is your child involved with other agencies in one capacity or another? If yes, please provide the name and the type of service.

Does your child have a history of any medical needs? If yes, please include past or current health issues, medications, allergies, etc.

CLIENT ASSESSMENT INFORMATION

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Client Name: _____ DOB: _____

Does your child have a history of substance use? If yes, please provide details.

Please check any past or present risk factors and explain below:

- ☐ **Homicidal/assaultive**
- ☐ **Suicidal/self-harm**
- ☐ **Access to weapons**
- ☐ **Trauma**
- ☐ **Neglect/Abuse**
- ☐ **Domestic Violence**
- ☐ **Legal Issues**
- ☐ **Crime/gang involvement**
- ☐ **Runaway**
- ☐ **Inappropriate/risky sexual behaviors**
- ☐ **Natural disaster**
- ☐ **Cognitive impairment**
- ☐ **Cultural Isolation**
- ☐ **Potential for victimization**
- ☐ **Risk of Homelessness**
- ☐ **Other**

Is your child impaired by any of the following? If yes, please explain below:

- ☐ **Health (physical conditions, activities of daily living)**
- ☐ **Daily Activities (work, school, leisure)**
- ☐ **Social Relationships (significant others, family, friends, support system)**
- ☐ **Home environment (homeless, maintaining current housing)**

Any additional information you'd like us to know (feel free to use the back page for more room):

CLIENT ASSESSMENT INFORMATION

TANAGER PLACE
YOUR CHILD : OUR FOCUS

1030 5th Ave SE | Cedar Rapids, IA 52403
P: (319) 286-4545 F: (319) 368-3358

2309 C St SW | Cedar Rapids, IA 52404
P: (319) 365-9164 F: (319) 365-6411

1150 5th St, Suite 160 | Coralville, IA
P: (319) 286-4520