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CHILD/ADOLESCENT BACKGROUND FORM

(to be completed by parent/guardian)

Child's name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex:_____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

List child's relatives including those by previous and subsequent marriages and any deceased siblings with date of death.

Name	**Age**	**Relationship**	**Grade or Occupation**	**Living in Household**

If not presently with the child, please give name and whereabouts of biological parent(s):

_____

_____

Legal custodian of child, if other than natural parent(s): _____

Is child adopted? _____ If yes, what age was he/she adopted? _____

Parent's marital status: (check all that apply):

- ❑ Married to each other
- ❑ Separated
- ❑ Divorced
- ❑ Widowed
- ❑ Mother remarried
- ❑ Father remarried
- ❑ Never married to each other; living: ❑ Separately ❑ Together

If the child's parents are divorced, who has legal custody? _____

What are the visitation arrangements? _____

Any problems with the arrangements? _____

How do the parents feel about this child? _____

Name and relationship to child of person completing form: _____

Who referred you to my practice? _____

Address of referral source: _____

May I contact them to thank them? ❑ Yes ❑ No

CHILD'S CURRENT PROBLEMS AND HISTORY

Describe the child's current problem(s) medical, behavioral, emotional):

_____

_____

_____

_____

_____

Please check any of the following which are problems for your child:

- ❑ Depressed
- ❑ Anxious
- ❑ Nervous habits
- ❑ Easily upset
- ❑ Panic Attacks
- ❑ Guilt feelings
- ❑ Tiredness & fatigue
- ❑ Sleep problems
- ❑ Shyness
- ❑ Nail biting/skin picking
- ❑ Self-destructive
- ❑ Extreme fears/phobias
- ❑ Self-critical
- ❑ Obsessions/compulsions
- ❑ Impulsive
- ❑ Feelings of worthlessness
- ❑ Hyperactivity
- ❑ Poor attention
- ❑ Poor concentration
- ❑ Memory problems
- ❑ Clumsiness
- ❑ School problems
- ❑ Difficulty following instructions
- ❑ Day-dreaming
- ❑ Speech problems
- ❑ Toilet concerns
- ❑ Jealousy
- ❑ Disorientation
- ❑ Elevated mood
- ❑ Oppositional
- ❑ Irritable
- ❑ Stealing
- ❑ Cruelty
- ❑ Fire setting
- ❑ Running away
- ❑ Temper tantrums
- ❑ Destructiveness
- ❑ Physical aggression
- ❑ Drug or alcohol abuse
- ❑ Sexually active
- ❑ Vandalism
- ❑ Verbal aggression
- ❑ Resentment
- ❑ Overly sensitive
- ❑ Eating problems
- ❑ Medical illness
- ❑ Delusions (believing things that are not true)
- ❑ Hallucinations (hearing voices/seeing things that are not there)
- ❑ Trauma History
  - ❑ Physical
  - ❑ Sexual
  - ❑ Emotional
  - ❑ Perpetrator

Risk Assessment: (underline all that apply)

Suicidality	Not present	Ideation	Plan	Means	Prior attempt
Homicidality	Not present	Ideation	Plan	Means	Prior attempt

Current Impairment: **Impairment Level**

Categories	No Impairment	Mild Impairment	Moderate Impairment	Marked Impairment	Extreme Impairment
Relationship/Family	1	2	3	4	5
Job/School/Performance	1	2	3	4	5
Friendship/ Peer relationships	1	2	3	4	5
Hobbies/Interests/Play Activities	1	2	3	4	5
Physical Health	1	2	3	4	5
Legal Status (Arrest, Probation)	1	2	3	4	5
Activities of Daily Living (personal hygiene, bathing, etc.	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleeping Habits	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5

When did the current problems start or when were they first noticed? _____

_____

Is your child aware of the problems(s)? _____ if yes, how is this awareness expressed: _____

_____

Has the possibility of evaluation been discussed with your child? _____

If yes, what was your child's reaction? _____

List all professionals and agencies which have been involved in the current problem(s), dates of contact, and whether it was beneficial:

_____ Date: _____ Beneficial? _____

_____ Date: _____ Beneficial? _____

_____ Date: _____ Beneficial? _____

Who disciplines your child(ren) and how? _____

_____

How does your child respond to discipline? _____

What are your child's strong points or favorable characteristics? _____

_____

What hobbies, sports or particular interests does your child enjoy? _____

_____

What kinds of things might serve as a reward for your child? _____

_____

What religion does your family belong to? _____ How involved is your child with a religious system? _____ Are your child's religious beliefs important to him/her? _____

SUBSTANCE USE AND DEPENDENCY

How often does your child currently use the following substances? (Place a check in the column to indicate current use; if your child's past use was different, indicate this by writing "past" in the appropriate column next to each substance.)

	Daily	3-5x/week	1-2x/week	2-3x/month	1/month	Seldom	Never
Beer	❑	❑	❑	❑	❑	❑	❑
Wine	❑	❑	❑	❑	❑	❑	❑
Distilled Alcohol	❑	❑	❑	❑	❑	❑	❑
Marijuana	❑	❑	❑	❑	❑	❑	❑
Cocaine	❑	❑	❑	❑	❑	❑	❑
Crack	❑	❑	❑	❑	❑	❑	❑
Barbiturates	❑	❑	❑	❑	❑	❑	❑
Amphetamines	❑	❑	❑	❑	❑	❑	❑
Tranquilizers	❑	❑	❑	❑	❑	❑	❑
Analgesics	❑	❑	❑	❑	❑	❑	❑
Heroin	❑	❑	❑	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑	❑	❑

Has your child had problems as a result of his/her substance use? _____ Describe _____
_____

Has anyone in your child's family ever had problems with substance abuse or dependency? _____

If so, who and what substances? _____

Has anyone in your family been involved in treatment for substance use or dependency? _____

If yes, who and what treatment? _____

Has anyone in your family been involved with a 12-step group (AA, Al-Anon, etc.)? _____

Current involvement? _____ What group(s)? _____

TREATMENT GOALS

List the benefits you hope your child receives from therapy. This is most important. Please be specific.

1. _____
2. _____
3. _____

Do you think your child would be helped more by: (check all that apply)

❑ Counseling with parents ❑ Psychological testing ❑ Counseling with child individually
❑ Family counseling ❑ Group therapy ❑ Medication
❑ Skills to change specific behaviors
❑ Other: _____

CHILD'S EDUCATION

School your child presently attends? _____ Grade: _____

Address: _____

Phone: _____ Principal: _____

How does your child do in school? (grades, ability, behavior) _____

_____

Has your child repeated any grades? _____ If yes, what grade and reason:_____

Has your child required any special assistance at school? _____ If yes, what kind of assistance? _____

_____ IEP? _____

Please list any behavior problems your child is having or has had in school: _____

_____

Any previous or current concerns with bullying? _____ If yes, please describe: _____

_____

CHILD'S DEVELOPMENT

Please list any problems encountered during the pregnancy and/or delivery and the first weeks of life: _____

_____

Was your child administered oxygen at birth? _____

EARLY DEVELOPMENT

Was your child an easy to care for infant? _____ If not, please explain: _____

_____

Was your child an easy to care for toddler? _____ If not, please explain: _____

_____

Please list any problems encountered in the first three years of life: _____

_____

Any head injuries related to falls or accidents? _____ If yes, please explain: _____

_____

If your child has started puberty, has the onset appeared to cause any difficulties? _____ If yes, please give details: _____

Has your child ever behaved or talked in a way that was not sexually appropriate for a boy/girl his/her age? _____ If yes, give details: _____

CHILD'S HEALTH

Name of family physician or pediatrician: _____

Address: _____

Does your child have any allergies? _____ If yes, please give details: _____

Has your child ever had a fever above 105 degrees? _____ If yes, please give child's age at the time, the cause and the treatment: _____

Has your child had any significant accidents or injuries (including broken bones)? _____ If yes, give

details _____

Has your child ever lost consciousness? _____ If yes, give details: _____

_____

Has your child had any operations? _____ If yes, give details: _____

_____

Has your child ever had seizures (convulsions)? _____ If yes, give details: _____

_____

Has your child received medications in the past for emotional, physical, or behavioral problems? _____

If yes, please give the following details:

Problem: _____

Age when first prescribed: _____ Medication: _____

Daily Dose: _____Times per day: _____ Taken since (date): _____

Who prescribed the medication(s)? _____

Benefits of medication: _____ Side effects: _____

Please describe any occurrences of birth defects, mental retardation, nerve disease (cerebral palsy, epilepsy) and psychiatric conditions in the immediate family and the child's blood relatives: _____

_____

_____

SIGNIFICANT EVENTS

Have any of the following events occurred in your family? If so, please describe:

Event	Year	Describe
❑ move to a new place	_____	_____
❑ significant separation from a parent	_____	_____
❑ loss of someone very close	_____	_____
❑ frightening experiences	_____	_____
❑ change of school	_____	_____
❑ serious illness or injury in family	_____	_____
❑ death in family	_____	_____
❑ change in family's financial status	_____	_____
❑ separation or divorce	_____	_____
❑ brother or sister leaving home	_____	_____
❑ marriage of sibling	_____	_____
❑ emotional difficulties	_____	_____
❑ legal problems	_____	_____
❑ other (specify)	_____	_____

HISOTRY OF PARENTS

How would you describe your marital relationship? _____

_____

Have you sought outside help with regards to marital problems? _____ If yes, please give details _____

_____

Have any extended family members had problems with substance abuse (drugs, alcohol)? _____

If yes, please give details _____

Have any extended family members been involved in incest (sexual interaction between a parent and child or between the children)? _____ If yes, please give details _____

_____

Has any family member been sexually, physically, or emotionally abused? _____ If yes, please give details _____

Please describe any problems that occurred while your child's father was growing up: _____

_____

Please describe any problems that occurred while your child's mother was growing up: _____

_____

Please describe any problems that occurred while your child's adoptive, step, or foster parent(s) or guardians were growing up: _____