♥ Child/Adolescent Background Information ♥

Today's Date:________________

<Identifying Information>

Child's Name(Last, First):	Date of Birth:________________ Age:______ Gender: M_____ F_____
Parents/Legal Guardians:	
Home Phone:____________________ OK to leave messages: Yes_____, No_____ Cell Phone:______________________ OK to leave messages: Yes_____, No_____ Work:__________________________ OK to leave messages: Yes_____, No_____ Email Address: OK to email: Yes_____, No_____	
Address: ____ OK to send letters: Yes_____, No_____	
Ethnicity: African American ( ), Asian ( ), Bi-racial ( ), Caucasian ( ) Hispanic/Latin ( ) Native American ( ), Other(explain)____	
School: _________________________________ Grade Level (Now):________________ School Teacher:___________________________ School Telephone:_________________ School Address:____	
Person we should contact in the event of an emergency: Name:_______________________________ Relationship:_________________ Phone Number:_______________________________________	
If child is not currently living with both biological parents, is either parent deceased?_____ if so, age of child at his/her loss:___________, please specify(when, how, etc):	
Were biological parents married?_____________	
Currently involved in a custody dispute: No_____, Yes_____ if yes, explain	
Are biological parents divorced/separated?_______ if so, when_________ Age of child at divorced/Separated:_______________________ Which parent has custody?__________________ How often does the non-custodial parent visit?_______________________________________ Have to provide <u>divorce decree/court document</u> prior to 1st meeting! If yes, please sign "Addendum To Child Therapy Contract" Signed: Yes_____ No_____	

<Referral Information>

1. By whom where you referred?____
2. Is your child currently on probation? No ___, Yes ___, Retained: No ___, Yes___
3. Is your child receiving special educational or other services? No ___, Yes ___
4. Has your child been seen previously for psychological or psychiatric treatment? Y/N:___
   If yes, Previous professional (Agency): _________________________________
   Phone:__________________ When:___________________ How long:_________________
   Was an evaluation completed?_____________ What type of evaluation?______________
   (If yes, please attach a copy of evaluation to this questionnaire)
   Will you grant permission for us to consult with this professional:
   (If yes, please sign attached "Authorization to request confidential information" form)

5. What do you enjoy most about your child?

____
____
____
____

6. Describe your major concerns, including duration of those concerns and any previous attempts to resolve them.

____
____
____

7. Please indicate with "X" mark how severe your concerns are at this point in time:
   _____ Mildly upsetting
   _____ Moderately severe
   _____ Very severe
   _____ Extremely severe
   _____ Incapacitating
8. How often does the problem behavior occur? (5x/day, 2x/week, etc)________________
9. How long has your child had this problems?____

____

10. How is this problem affecting your child at home? In school? In peer relationship?

____
____
____
____
____

11. What is the one thing I need to know to help your child today?

____
____
____
____

12. Anything else you think I need to know?

____
____
____

<Background Information>

General Information

1. Child's Current Household:

Mother only _____, Father only _____ , Natural parents _____, Foster family_____ Natural mother and Step-father _____, Natural father and Step-mother _____, Blended family (both spouses with children) _____, Relatives _____, Adoptive parents _____ (Date of adoption:___________________ Age of child at adoption:), Other:

2. Please list child's current family, beginning with the oldest member and include the child (including the child being referred)

Name	Date of Birth	Age	Gender	Relationship to Child

3. Please list other persons closely involved with child but not living in child's home (e.g., older siblings, grandparents, sisters, teachers, religious leaders, etc.)

Name	Relationship to Child	Place of Residence	Frequency of Visits

4. How long have you lived at the current address?________________
5. How often have you changed residences since the birth of this child?_______________
6. Does the child share a bedroom? Yes___, No___ If yes, with whom?_________________
7. Does your child have any difficulty with siblings? If yes, please explain_______________
   ____
   ____
8. Was the child ever placed or boarded away from the family? Yes___, No___
   If yes, where and with whom? ____
   ____
   Reason for placement____
9. Has your child ever had difficulty or contact with legal authorities (Police, Juvenile Justice)? If yes, please describe circumstances ___________________________________
   ____
10. Please describe any religious or cultural beliefs you would like incorporated into your child's treatment. ____

Mother's Information

Mother's Name(Last, First):	Date of Birth:_______________ Age:_____ Occupation: __________________
Home Phone:_____________________ OK to leave messages: Yes_____, No_____ Cell Phone:_______________________ OK to leave messages: Yes_____, No_____ Work:___________________________ OK to leave messages: Yes_____, No_____	
Address(if different from child):	
Education Level: 8th Grade or Below ( ), High School ( ), Some College ( ), College Graduate ( ) Master's Degree ( ), Ph.D. Degree ( ), Post Doctoral Work ( )	
Marital Status: Never Married ( ), Married ( ), Remarried ( ), Divorced ( ) Separated ( ), Widowed ( ), # of Marriage ( )	

Father's Information

Father's Name(Last, First):	Date of Birth:_______________ Age:_____ Occupation: __________________
Home Phone:_____________________ OK to leave messages: Yes_____, No_____ Cell Phone:_______________________ OK to leave messages: Yes_____, No_____ Work:___________________________ OK to leave messages: Yes_____, No_____	
Address(if different from child):	
Education Level: 8th Grade or Below ( ), High School ( ), Some College ( ), College Graduate ( ) Master's Degree ( ), Ph.D. Degree ( ), Post Doctoral Work ( )	
Marital Status: Never Married ( ), Married ( ), Remarried ( ), Divorced ( ) Separated ( ), Widowed ( ), # of Marriage ( )	

Parental History

Parent's history of learning, emotional, or behavioral problem: Yes ( ), No ( ) if yes, mother____, father_____, or both______, please explain:
Parent's history of alcohol/drug/substance abuse: Yes ( ), No ( ) if yes, mother____, father_____, or both______, please explain:
Parent's history of domestic violence: Yes ( ), No ( ) if yes, mother____, father_____, or both______, please explain:
Parent's history of criminal activity: Yes ( ), No ( ) if yes, mother____, father_____, or both______, please explain:
Parent's history of sexual/verbal/mental abuse: Yes ( ), No ( ) if yes, mother____, father_____, or both______, please explain:

Child's Family History

1. Your child is raised by:
   _____ Natural parents _______Single natural parent _______Grandparents
   _____Adoptive parent(s) _______Natural and step-parent _______Foster parents
   _____Institution _______Relatives _______Other( )
2. Please indicate if any of the following items are **currently** being experienced within the immediate family (parents, siblings):

	Marital difficulties		Recent move/moved a lot
	Spouse abuse		Separation from family member (incarceration etc.)
	Divorce/separation of parents		Financial problems
	Serious illness of parent, child, sibling (specify:_________________________________)		Child physical, sexual, and emotional abuse & neglect (specify:______________)
	Family member's disability or major accident		Single parent
	Birth of new child		Job loss
	Death in family		Parents fighting frequently
	Family member absent (explain____________)		Family member suicide (explain_____________)

3. Please indicate which of the following concerns have you been experienced in the immediate and/or extended family (parents, siblings, aunts, uncles, cousins, grandparents)

Concern		Relationship to Child (specify maternal or paternal and relationship)
	Autism Spectrum Disorders	
	Learning Disabilities	
	Mental Retardation	
	Birth Defects	
	Cancer	
	Diabetes	
	Attention Deficit Hyperactivity Disorder (ADHD)	
	Alcoholism	
	Drug Addiction	
	Depression	
	Bipolar Disorder	
	Suicide (threats/attempts/completed)	
	Anxiety	
	Phobias (specify:___________________________)	
	Psychiatric Hospitalizations	
	High Blood Pressure	
	High Cholesterol	
	Hear Disease	

4. Trauma history on child abuse and neglect (indicate all that apply):
   _____Physically, _____Emotionally, ______Sexually, ______Neglect, _______Traumatic loss
   _____Multiple placements, ______Abandonment,

_____ Child separated from parent (how long and when:_______________________________
____)
______Death of a significant person (name:____
Relationship to child:__________________________ Date of death_____________)
_____ Abuse of pet _____ Death of pet ______Incarcerated family member
_____ Sexual assault _____ Victim of trauma(unusual, terrifying experience)
______ Medical ______Natural disaster
_____ Other (explain:____)
CPS report & by who?____
CPS report outcome____

5. Family atmosphere (circle the number that best describes how you think **your child views** the atmosphere in your home):

Very lenient 1__________2__________3__________4__________5 Very strict
Very non-religious 1__________2__________3__________4__________5 Very religious
Flexible 1__________2__________3__________4__________5 Highly structured
Few expectations 1__________2__________3__________4__________5 High expectations
Inconsistent 1__________2__________3__________4__________5 Consistent

6. Family support system (such as church, friends, relatives, school)

Hardly any support 1__________2__________3__________4__________5 Considerable support

7. Circle appropriate number of hours your child spends watching TV each week:
   0-2__________3-5__________6-8__________9-14__________14+
8. Circle appropriate number of hours your child spends watching Computer/video each week:
   0-2__________3-5__________6-8__________9-14__________14+

Child's Medical Information

1. Date of LAST complete physical:_____________________ Result:_________________
2. Physical Disability: Yes ( ), No ( ) (if yes, explain)________________________________
3. Chronic Illness: Yes ( ), No ( ) (if yes, explain)________________________________
4. Primary Care Physician: ________________________Tel:________________________
   Address:____'
5. Is the child a twin (or other multiple)?______________ identical?_______________
6. How long was pregnancy? ____ months. Any complications?____, if so, describe
   ____
7. How long was labor?_____ hours. Any complications?_____, if so, describe
   ____
8. Was delivery through natural childbirth?___________ or C-section?_________________
9. Was delivery in the hospital?______, home?______, other?(please specify)_______
10. Were there any complications during delivery?_____, if so, describe ________________
11. Child's birth weight _______, Height _______, Any complications following delivery?___
    If so, describe ____
12. How long did mother and child remain hospitalized after delivery?_________________
13. Please indicate with an "x" any illness or disease which your child has had, and indicated date:

	Adverse drug reactions		Chickenpox
	Allergies (specify:________________)		Measles
	Asthma		Mumps

	Frequent/recurring….		Surgeries, such as:
	[ ] Colds		[ ] Appendectomy
	[ ] Gastrointestinal problems		[ ] Heart Surgery
	[ ] Headaches		[ ] Tonsillectomy
	[ ] High fevers		[ ] Other (specify:__________)
	[ ] Influenza		
	[ ] Migraine headaches		
	[ ] Pneumonia		
	[ ] Seizures		
	[ ] Sinusitis		
	[ ] Sore throats		
	[ ] Strep throat		
	Broken bones (specifiy:_____________)		Substance abuse
	Dizziness/Fainting		Arthritis
	High/Low blood pressure		Cancer
	Insertion/removal of tubes		Cerebral palsy
	Diabetes		Meningitis
	Diphtheria		Polio
	Encephalitis		Tuberculosis
	Exposure to lead		Other (specify:___________________)

14. Has your child ever hit his/her head?
15. Has your child ever been hospitalized overnight? __________________

Condition for which hospitalized	Date	Length of hospitalization

Name of Pediatrician____

16. Is your child currently on may medications or dietary supplements?__________________

Medication & Dosage	Diagnosis	Prescribing physician/psychiatrist	Date of initial prescription

(If you do not know the name and dosage of current medication, please bring the medication to your next session.)

17. Physician/Psychiatrist prescribing medication: Name: _____________________
Tel: _______________________Address:____
18. Does your child have any vision problems?___________________
19. Does your child wear glasses?______________ Contact lenses?__________
20. Glasses/Lenses prescribed, but child does not wear? Yes_____, No_____
21. Date of last vision exam____________, Results: Right eye_____/20, Left eye_____/20
22. Does your child have any hearing problems?_____, if so, does your child require hearing aids or other devices to amplify sounds?______ Specify:____________________________

23. Number of hours of sleep per night________
24. Frequent waking or nightmares?___, if so, specify (frequency, etc):_________________
    ____
25. Do you have concerns about your child's weight?__________________________________
26. What percentage of food is home cooked?__________________
27. Describe any unusual eating habits (picky eater, eating nonedible items, etc.)
    ____
28. Please list any known food/drug allergies:____

Child's Developmental Information

Early Childhood:

Please indicate with an "x" in each column to indicate when your child demonstrated each development milestone:

Child walked:		**Child spoke words:**		**Child spoke sentences:**	
	< 12 months		< 12 months		< 12 months
	12-24 months		12-24 months		12-24 months
	24-36 months		24-36 months		24-36 months
	> 36 months		> 36 months		> 36 months
	Has never walked		Has never spoken words		Has never spoken sentences

Child first trained for urination:		**Child first trained for bowels:**	
	< 12 months		< 12 months
	12-36 months		12-36 months
	3-5 years		3-5 years
	> 5 years		> 5 years
	Not yet trained		Not yet trained

Since initial toilet training:		**Since initial toilet training:**	
	Frequent wetting during day		Frequent soiling during day
	Frequent wetting during night		Frequent soiling during night

Puberty:

Please indicate with an "x" to indicate when your child first demonstrated:

Onset of puberty (breast development, menstruation, public hair, facial hair):			
	< 10 years		14-16 years
	10-12 years		> 16 years
	12-14 years		Not yet developed

Child's Educational Information

1. List all schools your child has attended, beginning with the most recent:

School	Grade	Date of Entry	Date of Withdrawal

(If this is an educational concern, please attach copies of report cards)

2. Has your child ever repeated a grade?____ Reason________________________________
3. Has your child ever had problems in school?_________________________
   Describe____
   ____
4. Please indicate with an "x" where you feel your child is performing academically:

Subject	Below grade level	On grade level	Above grade level
Language Arts/Reading			
Mathematics			
Writing			

5. Does your child enjoy attending school?_____ if no, please explain___________________
   ____
6. Has your child ever been referred for education interventions, such as additional academic assistance, behavioral management plans, etc?____ if yes, please describe___
   ____
7. Is your child currently on a 504 plan?___________ Diagnosis________________________
   504 plan interventions____
8. Is your child currently in Special Education?_____ Date of most recent IEP ___________
   Education disability_____________________ Services receiving ______________________
9. Do you feel the interventions (informal/504/Special Education) are effective?_________
   If no, please explain ____

Child's Academic/Social/Emotional/Behavioral Checklist

Please indicate with an "x" if your child is currently exhibiting difficulty with any of the following (for the most serious concern, please circle the item)

Academic:

Reading -- Basic Skills			Difficulty completing problems with more than one step
	Difficulty recognizing letters	**Math Reasoning**	
	Difficulty reciting the alphabet		Difficulty understanding concepts related to size, sequence, or quantity
	Difficulty reading aloud (loses place or skips words)		Difficulty identifying and using appropriate problem-solving strategies
	Dislikes reading / reluctant to read		Difficulty solving word problems
	Reads slowly		Difficulty completing problems involving estimation or prediction
Reading – Comprehension			Difficulty understanding charts, tables, and graphs
	Difficulty understanding the meaning of words		Difficulty generalizing math skills to other types of problems or tasks
	Difficulty understanding the mean of passages		Difficulty understanding abstract mathematical concepts
	Difficulty identifying main idea	**Written Expression**	
	Difficulty drawing conclusions		Difficulty writing information dictated by others

	Difficulty following written directions		Difficulty with basic mechanics of writing
	Difficulty understanding idioms or figurative language		Confuses the order of words in sentences
Math Calculation			Writes in incomplete sentences
	Difficulty identifying numerals		Uses simplistic language when writing
	Difficulty counting by rote		Difficulty expression ideas in writing
	Difficulty understanding basic arithmetic facts		Dislikes/avoids written tasks
	Difficulty completing problems involving basic calculation		Poor handwriting (difficulty with letter formation, poor spacing between letters and words)
	Difficulty completing problems involving fractions or decimals		Difficulty copying from blackboard
	Difficulty completing problems involving geometric shapes		
Oral Expression		**Listening comprehension – cont.**	
	Confuses or leaves out speech sounds		Exhibits short attention span during auditory tasks
	Dysfluency (unusual pauses or repetitions, frequent rephrasing, poor verbal organization)		Difficulty understanding sentences that are long or complex
	Grammatical problems (incorrect use of plurals, verb tense forms, pronouns, etc.)		Confuses similar words
	Limited vocabulary		Cannot remember information presented verbally
	Word retrieval problems		Cannot remember information that was just spoken
	Problems with social language (Initiating conversations, expressing thoughts and feelings, asking questions, etc.)		Cannot repeat information that was just spoken
	Does not speak in class to teachers/students		Appears disinterested in audio information (tapes, recordings, etc.)
Listening comprehension			Demonstrates disruptive or off-task behaviors when required to listen
	Difficulty following oral directions		Difficulty responding to questions within expected time limits
	Frequently asks for repetition or oral instructions		
	Misunderstands spoken word		
	Easily distracted by noises or other sounds		

Social:

	Misinterprets facial expressions or body language		Displays attention—getting behaviors, acts like "class clown"
	Overreacts to perceived insults		Misinterprets tone of voice
	Does not understand teasing, sarcasm, jokes		Isolated from others – few group or social interactions
	Has few or no friends		Withdrawn—does not make eye contact,

			seems introverted, does not participate in discussions

Emotional:

	Excessive crying		Gives up when challenged
	Overreacts to normal situations with excessive anger, fear, sadness, etc		Appears depressed
	Feeling guilty or shameful		Feeling sadness depression or suicidal urges **related to grief.**
	Disturbing memories (past abuse, neglect or other traumatic experience)		Feeling sadness depression or suicidal urges **NOT related to grief.**
	Excessive fear and often worried		Appears excessively angry
	Unexplained fears and anxiety		Separation anxiety
	Frequent nightmares or bad dreams		Low self-esteem
	Excessive happy		Major weight loss or unexplained weight loss
	Excessive anger or aggressive behaviors		Lacking interest in things once enjoyed
	Loss of energy		Recent changes in sleeping and eating patterns
	Feeing fatigue		Heard voices when no one was around
	Eating too much or major weight gain		Suicidal thoughts
	Excessive complaints about aches and pains		Suicidal attempts
	Feeling overwhelmed by life		Previous suicidal thoughts & attempts

Behavioral:

	Excessively out of seat		Engages in risky behaviors
	Regression (baby talk, bed wetting, or thumb sucking)		Frequent temper tantrums
	Refuses to comply with requests		Associates with children that have been in trouble
	Parent-Child relationship		Sleep problem (nightmares, night-terror, sleeping too much or too little, etc.)
	Delayed development		Overreacting to things
	Frequently off-task		Difficulty focusing
	Withdrawn		Poorly organized
	Interrupts others when speaking		Experiences difficulty starting tasks
	Uses foul language		Acts before thinking
	Frequently fights or arguments with peers		Can't sit still
	Frequently fights or arguments with adults		Experiences difficulty planning
	Frequent fights or arguments with family members		Problems at school (disrespectful behaviors, class-cutting, and absenteeism)
	Persistent disobedience		Poor Grades/A sudden drop in grades
	Bed wetting and related problems/ soiling		Abuse (physical, emotional, sexual)
	Health concerns (physical complaints and/or medical problems)		Sexual concerns (excessive masturbation, inappropriate acting out, inappropriate display of sexual knowledge)

	Misbehaved a lot		Troubled with law/involved with the juvenile system
	School refusal		Not completing school work/tasks
	Impulsive		Ran away
	Alcohol and/or drug use		Hyperactive
	Accident—prone		Slapping, hitting, shoving
	Temper outbursts		Attention problems/Poor concentration
	Serious depression (Listlessness, loneliness, withdrawal, or difficulty making friends)		A need to wash, count, or perform certain rituals many times per day to avoid unsubstantiated danger
	Serious over-eating or under-eating		Inappropriate sexual comments and/or behaviors
	Daydreaming		Taken advantage of
	Severely teased		Adjustment to life changes (changing schools, parent's divorcing, moving, etc.)

Additional Comments:
Please use the space below to describe any other information you feel would be helpful to us in understanding your concerns.

____
____
____
____
____

Thank you for taking the time to complete this questionnaire thoroughly!