

**♥ 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 divorce decree/court document 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)

1. What do you enjoy most about your child?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate with “X” mark how severe your concerns are at this point in time:

\_\_\_\_\_ Mildly upsetting

\_\_\_\_\_ Moderately severe

\_\_\_\_\_ Very severe

\_\_\_\_\_ Extremely severe

\_\_\_\_\_ Incapacitating

1. How often does the problem behavior occur? (5x/day, 2x/week, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long has your child had this problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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: |

1. 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 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. 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 |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. How long have you lived at the current address?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How often have you changed residences since the birth of this child?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Does the child share a bedroom? Yes\_\_\_, No\_\_\_ If yes, with whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Does your child have any difficulty with siblings? If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Was the child ever placed or boarded away from the family? Yes\_\_\_, No\_\_\_

If yes, where and with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for placement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child ever had difficulty or contact with legal authorities (Police, Juvenile Justice)? If yes, please describe circumstances \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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( )

1. 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\_\_\_\_\_\_\_\_\_\_\_\_ ) |

1. 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 |  |

1. 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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

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

Hardly any support 1\_\_\_\_\_\_\_\_\_\_2\_\_\_\_\_\_\_\_\_\_3\_\_\_\_\_\_\_\_\_\_4\_\_\_\_\_\_\_\_\_\_5 Considerable support

1. Circle appropriate number of hours your child spends watching TV each week:

0-2\_\_\_\_\_\_\_\_\_\_3-5\_\_\_\_\_\_\_\_\_\_6-8\_\_\_\_\_\_\_\_\_\_9-14\_\_\_\_\_\_\_\_\_\_14+

1. 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’

1. Is the child a twin (or other multiple)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ identical?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How long was pregnancy? \_\_\_\_ months. Any complications?\_\_\_\_, if so, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. How long was labor?\_\_\_\_\_ hours. Any complications?\_\_\_\_\_, if so, describe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Was delivery through natural childbirth?\_\_\_\_\_\_\_\_\_\_\_ or C-section?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Was delivery in the hospital?\_\_\_\_\_\_, home?\_\_\_\_\_\_, other?(please specify)\_\_\_\_\_\_\_
3. Were there any complications during delivery?\_\_\_\_\_, if so, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Child’s birth weight \_\_\_\_\_\_\_, Height \_\_\_\_\_\_\_, Any complications following delivery?\_\_\_

If so, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How long did mother and child remain hospitalized after delivery?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. 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….

|  |  |
| --- | --- |
|  | Colds |
|  | Gastrointestinal problems |
|  | Headaches |
|  | High fevers |
|  | Influenza |
|  | Migraine headaches |
|  | Pneumonia |
|  | Seizures |
|  | Sinusitis |
|  | Sore throats |
|  | Strep throat |

 |  | Surgeries, such as:

|  |  |
| --- | --- |
|  | Appendectomy |
|  | Heart Surgery |
|  | Tonsillectomy |
|  | Other (specify:\_\_\_\_\_\_\_\_\_ ) |

 |
|  | 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |

1. Has your child ever hit his/her head?
2. Has your child ever been hospitalized overnight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Condition for which hospitalized | Date | Length of hospitalization |
|  |  |  |
|  |  |  |
|  |  |  |

 Name of Pediatrician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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.)*

1. Physician/Psychiatrist prescribing medication: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does your child have any vision problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your child wear glasses?\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact lenses?\_\_\_\_\_\_\_\_\_
3. Glasses/Lenses prescribed, but child does not wear? Yes\_\_\_\_\_, No\_\_\_\_\_
4. Date of last vision exam\_\_\_\_\_\_\_\_\_\_\_, Results: Right eye\_\_\_\_\_/20, Left eye\_\_\_\_\_/20
5. Does your child have any hearing problems?\_\_\_\_\_, if so, does your child require hearing aids or other devices to amplify sounds?\_\_\_\_\_\_ Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Number of hours of sleep per night\_\_\_\_\_\_\_\_
7. Frequent waking or nightmares?\_\_\_, if so, specify (frequency, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have concerns about your child’s weight?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. What percentage of food is home cooked?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Describe any unusual eating habits (picky eater, eating nonedible items, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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)

1. Has your child ever repeated a grade?\_\_\_\_ Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has your child ever had problems in school?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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 |  |  |  |

1. Does your child enjoy attending school?\_\_\_\_\_ if no, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child ever been referred for education interventions, such as additional academic assistance, behavioral management plans, etc?\_\_\_\_ if yes, please describe\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child currently on a 504 plan?\_\_\_\_\_\_\_\_\_\_\_ Diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

504 plan interventions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is your child currently in Special Education?\_\_\_\_\_ Date of most recent IEP \_\_\_\_\_\_\_\_\_\_\_

Education disability\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Services receiving \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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!



HopeSpring Child & Family Clinic, LLC

703-259-5617 • Fax: 703-552-2037

3915 Old Lee Hwy #23A Fairfax, VA 22030

Info@hopespringchildandfamily.com • [www.hopespringchildandfamily.com](http://www.hopespringchildandfamily.com)