Child Background Information Form

(to be completed by parent)

Date Completed___________________________ **Date Received**__________________

NAME OF CHILD_______________________________ Date of Birth __________Age _____

NAME OF PERSON COMPLETING THIS FORM_____________________________________

NAME OF PARENTS OR LEGAL GUARDIANS____

____

LEGAL STATUS OF PARENTS

NEVER MARRIED MARRIED SEPARATED DIVORCED

COURT ORDER OF CUSTODY

NO YES, SOLE LEGAL CUSTODY YES, JOINT LEGAL CUSTODY

IF Joint legal custody, has the consent of all parties or a court order been obtained?

YES NO[2]

ADDRESS OF CHILD______

____

Home Phone: (___ _)__________________ **May we leave msg? YES NO**

Parent 1: Name ____

Cell/Other phone: (_____)_____________May we leave a msg? YES NO

Parent 2: Name____

Cell/Other phone: (_____)_____________May we leave a msg? YES NO

____

Parent 3: Name____

Cell/Other phone: (_____)_____________May we leave a msg? YES NO

Parent 4: Name____

Cell/Other phone: (_____)_____________May we leave a msg? YES NO

Emergency Contact: NAME _________________________Phone: ________________

List the people currently living in the child's primary residence

Name	Age	Relationship to You	Occupation

List the people currently living in the child's secondary residence

Name	Age	Relationship to You	Occupation

Who referred the child/family for counseling?

____

Briefly describe your concerns that caused your child/family to seek therapy:

____

____

____

Briefly describe your goals for your child's/family's therapy:

____

____

____

Mental Health Background

List any psychotropic medications that your child is taking.

Medication	Dose/Frequency	When Started	For What Symptom(s)?

List any previous mental health or substance abuse treatment (include any inpatient or hospital treatment for a mental health or substance abuse disorder) that your child has had.

Date of Treatment (approximate)	Name of Treatment Provider or Agency	What Was Your Problem at the Time?	Were Your Treatment Goals Met?

Was anything in the previous treatment particularly helpful? Not helpful?_______________

____

____

At this time does your child ever have thoughts of self-harm? YES ______ NO __________

Have your child ever attempted suicide? YES ______ NO __________

At this time does your child ever think of harming others? YES ________ NO __________

Developmental History[3]

Prenatal/perinatal

Did the mother experience any potentially serious health problems during pregnancy such as high blood pressure, toxemia, RH incompatibility, measles, etc?

YES NO

If so, what were they?

____

____

____

____

Was your child born prematurely?

YES NO

If yes, how many weeks premature?_______________

What was the baby's weight at birth? ________ pounds _____ ounces

Did your child experience any difficulties at birth such as breathing problems, oxygen deprivation, use of incubator, etc.

YES NO

If yes, what were the problems?

____

____

____

____

Was your child substantially late in learning to

sit up_____ crawl______ walk _____ talk_____

other developmental steps? __________

Does your child show any aversions to

___sounds ___tastes ___touch ___sights

Does your child show any significant preference for a particular

___sound ___taste ___touch ___sight

Has your child ever received services through Early Intervention or the Intermediate Unit?

If Yes, please provide beginning and end dates of services, what services were provided and how many hours of each service.

____

____

____

Education

Education (please circle highest grade in school)

K 1 2 3 4 5 6 7 8 9 10 11 12

Current School____

School address____

Primary/home room teacher______________________________________

What type of Education setting is your child in?

__Regular Ed __Emotional Support __Life Skills __Resource Rm __Autistic Support

Does your child have a current IEP? __Yes __No

How many schools has your child attended?_________________________

Has your child received any psychological testing and/or educational testing? __Yes __No

If yes, please indicate when and evaluation was completed, its purpose and any diagnosis given:

____

____

Would you describe your child as a:

good student average student poor student

likes school okay with school dislikes school

very well-behaved in school well-behaved in school behaves poorly in school

Other Questions

Describe your child's religious or spiritual orientation? ________________________________

If you have a religion, how often does your child attend religious services? (Circle one)

At least weekly monthly several times a year once a year or less

Which of the following statements best describe your child (check all that apply)

_____ Has a lot of friends to confide in or count on
_____ Has close family members to confide in or count on
_____ Has a few close friends to confide in or count on
_____ Has a few close family members to confide in or count on
_____ Has a lot of friends, but can't confide in them or count on them
_____ Has few friends and none to confide in or count on

Would you say that your child is lonely?

_____ frequently _____ occasionally _____ sometimes _____ rarely

Does your family have a history of mental illness or substance abuse? If so, please explain the nature of the problem, treatment they received and indicate if any particular medication was helpful.

____

____

____

Legal History

Has your child ever been arrested or involved in litigation?

YES NO

If yes, please explain.____

____

____

____

____

____

____

Medical Information

Name of primary care physician or provider ______________________________

Do I have your permission to send basic information (presenting problem, summary of treatment, relevant health information, etc.) to your child's pediatrician or primary care provider?

YES ________ **NO** __________

If yes, you will need to sign a specific "authorization" or "release of information form" in order for me to contact your child's primary care provider.

How would you describe your child's current physical health?

___ excellent ___ good ___ average ___ poor ___ very poor

List any medical conditions that your child has.

Medical condition or symptoms	Treatment (s)

List any prescription medications that your child takes.

Drug	**Dose/Frequency**	**When Started**	**For What Symptom(s)?**

List any non prescription (over-the-counter) medications that your child takes?

Drug	Dose/Frequency	When Started	For What Symptom(s)?

Does your child have any allergies or sensitivities to drugs, foods, or other substances?

YES _________ NO ___________

If yes, please indicate the substances that your child is allergic to or has sensitivities to:

____

____

Do your child smoke or use other tobacco products, drink alcohol, or use recreational drugs (such as marijuana, cocaine, or other drugs)?

YES _________ NO ___________

If yes, please give more details such as nature of use and frequency.

____

____

What are your family's strengths?

____

____

____

What activities does your family enjoy doing together?

____

____

____

Please wait to sign this form during your initial session.

_____________________________________ _____________
Parent/Legal Guardian Signature Date

____
Parent/Legal Guardian Name (PRINTED)

_____________________________________ _____________
Elizabeth Soucar, Ph.D. Date