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Child Background Summary

I. Identifying Information:

Today's Date: _____

Child's Name: _____

Age: _____

Date of Birth: _____

Parent or Guardian's Name: _____

Address: _____

_____

Home Phone # _____

Work Phone # _____

E-mail address: _____

If I need to contact you, do you have a preference about which phone number I use or how I identify myself? No _____ Yes _____

If yes: What are your preferences? _____

_____

How were you referred to me? _____

II. Household Configuration:

Who is currently living in your home?

Name	Age	Relationship to Child

For blended families or households with divorced parents, please provide the following information:

Who is the child's legal guardian? _____

What is the parenting time schedule? _____

_____

Is there ongoing or pending litigation concerning custody or parenting time?

No _____ Yes _____

III. Main Problem:

Please describe the symptoms or problems that your child is experiencing

How long has your child had these problems? _____

What people, situations, or events seem to trigger these problems or make them worse?

What seems to help?

Has your child presented any of the following problems?

- ☐ Easily distracted
- ☐ Difficulty following directions
- ☐ Is irritable
- ☐ Overeats
- ☐ Refuses to eat
- ☐ Fidgets or squirms in seat
- ☐ Often loses temper
- ☐ Often spiteful or vindictive
- ☐ Deliberately does things that annoy others
- ☐ Wets the bed
- ☐ Soils his/her pants
- ☐ Refuses to go to school
- ☐ Often argues with adults
- ☐ Is anxious or fearful
- ☐ Isolates himself/herself from others
- ☐ Cries Frequently
- ☐ Worries excessively
- ☐ Says he/she wants to die
- ☐ Injures himself/herself
- ☐ Repeats certain acts compulsively
- ☐ Has stolen something
- ☐ Has run away overnight
- ☐ Lies
- ☐ Sets fires on purpose
- ☐ Initiates fights
- ☐ Has engaged in inappropriate sexual activity
- ☐ Drinks alcohol
- ☐ Uses drugs

IV. Treatment History:

Has your child been treated for emotional or behavioral problems? No _____ Yes _____

If Yes, by whom?

Psychologist Psychiatrist Other counselor Primary Care Physician

Name of treatment provider: _____

Has your child ever taken medication to help with behavioral or emotional problems?

No _____ Yes _____

If Yes, please provide the following information:

Medication	Dose	Dates Taken	Did it help?	Side effects (if any)

V. Family History :

Do emotional or psychological problems run in your family? No _____ Yes _____

If Yes, please provide the following information

Family Member	Problem	Type of Treatment

VI. Developmental History:

Were there complications during this child's birth or during the pregnancy? No _____ Yes _____

If Yes, please describe: _____

_____

Please indicate at what age your child:

Sat up unassisted _____ Walked _____ Began speaking in whole sentences _____

Toilet trained _____ Began reading _____

Were you ever concerned that your child was not mastering cognitive, social, or physical skills as quickly as he or she should be? No _____ Yes _____

If yes, please explain: _____

_____

Has your child experienced any serious medical problems? No _____ Yes _____

If Yes, please specify: _____

Has your child ever suffered a head injury or been knocked unconscious? No _____ Yes _____

If Yes, please specify: _____

VII. Educational History:

Current school: _____

Grade: _____ Teacher Name: _____

Please circle your child's typical academic marks: A B C D F

Please comment on your child's academic strengths:

Please comment on your child's academic weaknesses:

Has your child ever repeated a grade? No _____ Yes _____

Has your child ever skipped a grade? No _____ Yes _____

Has your child been placed on an IEP (Individual Educational Plan) at school? No _____ Yes _____

If Yes, in what areas? _____

VIII. Situational Stress:

Please indicate whether your child or family has experienced any of the following stressful events:

- ☐ Death in the family: _____
- ☐ Difficulties at school: _____
- ☐ Injury or illness: _____
- ☐ Persons moving in or leaving the home: _____
- ☐ Legal Problems: _____
- ☐ Adult relationship problems: _____
- ☐ Financial problems: _____
- ☐ Changes in residence or school: _____
- ☐ Other significant changes: _____

IX. Interests and Talents:

Is your child involved in any extracurricular activities? No _____ Yes _____

If Yes, please list activities: (1) _____

(2) _____

(3) _____

How many friends does your child have? _____

Does he or she have a best friend? No _____ Yes _____

Please list any interests or hobbies your child enjoys:

(1) _____

(2) _____

(3) _____

What is your child particularly good at?

What are your child's most endearing qualities?