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IDENTIFYING INFORMATION

Person Completing this form: ☐Parent ☐ Grandparent ☐Guardian ☐Other:_____

Child's Name: (FIRST)_____(LAST)_____(MIDDLE)_____ Sex: (M) ☐ (F) ☐

DOB: _____ Hospital/City/State _____ Age: _____

Social Security Number: _____ Referred By: _____

Mother's Name: _____ DOB: _____
☐ Natural parent ☐ Relative
☐ Step Parent ☐ Adoptive Parent

Father's Name: _____ DOB: _____
☐ Natural parent ☐ Relative
☐ Step Parent ☐ Adoptive Parent

Child Address (Number and Street): _____

City: _____ State: _____ Zip: _____

Mother Phone: _____ Father Phone: _____ Guardian Telephone: _____

E-mail:_____

OK to contact: ☐Mother ☐Father ☐Guardian

OK to leave message: ☐Mother ☐Father ☐Guardian

Emergency Contact: _____ Relation: _____Phone #: _____

Primary Care Physician: _____ Insurance Provider: _____
Please provide Insurance/Medicaid card

For what are you seeking help with today? _____
_____
_____.

Presenting Problems (check all that apply):

__ Temper outbursts	__ Impulsive	__ Shy	__ Other (explain):
__ Withdrawn	__ Stubborn	__ Strange behavior	_____
__ Daydreaming	__ Disobedient	__ Stealing	_____
__ Fearful	__ Infantile	__ Lying	_____
__ Clumsy	__ Mean to others	__ School trouble	_____
__ Overactive	__ Destructive	__ Bowel/bladder control	
__ Short attention span	__ Bed wetting	__ Feeding/Eating problems	
__ Distractible	__ Self mutilating	__ Sleeping problems	
__ Peer conflict	__ Head banging	__ Drug/Alcohol use	
__ Phobic	__ Rocking	__ Sickly	

PAST MENTAL HEALTH TREATMENT

Has the Child ever been in the hospital for mental health treatment? **Yes No**
Has the Child ever been in outpatient care for mental health treatment? **Yes No**
Has the Child ever been in an in-school treatment program? **Yes No**
Has the Child ever been in a residential treatment center? **Yes No**

Name of Facility Location Reason for Treatment Start/End Dates How did child do?

_____

_____

_____

_____

Was treatment completed? **Yes No**
Did Child have a positive experience in previous treatment? **Yes No**
Was Child compliant with treatment recommendations? **Yes No**
Comments regarding treatment history: _____

_____

Do you feel that the child is at risk for dangerous behaviors? **Yes No**

What situations increase the risk for dangerous behaviors? _____

_____

What does child do to cope with these risks? _____

_____

Describe any warning signs for the dangerous behaviors: _____

_____

TRAUMATIC EVENTS

Current or past experience of being abused or neglected? **Yes No**

Please explain: _____

Any other traumatic experience?: _____

_____

Has the child received services for the past abuse? **Yes No**

MEDICAL HISTORY

Has the child ever been hospitalized for illness, physical ailments, emotional problems etc? Y___ N___
If yes, please explain where, when, and what for? _____
_____
_____.

Does the child have any allergies that you are aware of (i.e. latex, peanut, soy, etc.)? _____

_____.

MEDICATIONS

Has Child taken any medications in the past two weeks? **Yes No**

Has Child taken any medications for any reason? **Yes No**

Was Child compliant with medications in the past? **Yes No**

Medications Taken (List All):

Name	**Dosage**	**Reason Prescribed and Date**	**Reason Ended and Date**

List any other medication not included above:

_____

_____

LIVING ARRANGEMENTS

CURRENT LIVING SITUATION

Is child in need of food, clothing, or shelter? **Yes No**

Describe: _____

_____

Current living arrangement: _____

_____

Number of persons, other than the Child, currently living in the home? _____

LIST HOUSEHOLD MEMBERS

Name	**Relationship**	**Age**	**Quality of relationship (1-5)**
1.			(poor) 1 2 3 4 5 (excellent)
2.			(poor) 1 2 3 4 5 (excellent)
3.			(poor) 1 2 3 4 5 (excellent)

4._____ (poor) 1 2 3 4 5 (excellent)

5._____ (poor) 1 2 3 4 5 (excellent)

6._____ (poor) 1 2 3 4 5 (excellent)

SPIRITUAL CONSIDERATIONS

Primary religious affiliation: _____

Does Child have spiritual strengths? **Yes** **No**

Does Child have spiritual concerns? **Yes** **No**

Describe: _____

_____

Have any **family members** had a history of

Mental Illness? **Yes** **No** If Yes, describe (give diagnosis if known): _____

_____

Substance Abuse? **Yes** **No** If Yes, describe: _____

_____

Criminal Activity? **Yes** **No** If Yes, describe: _____

_____

Violent Behavior? **Yes** **No** If Yes, describe: _____

_____

Medical Problems? **Yes** **No** If Yes, describe: _____

_____

DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? Y____ N____ If yes, please explain

_____

_____

_____.

Did mother abuse alcohol or drugs during pregnancy? Y____ N____

Length of pregnancy: _____ Full Term? Y____ N ____ Birth Weight ____lbs _____oz

Complications at birth? (Explain)_____

_____

_____.

As far as you know, did your child meet developmental milestones at an appropriate age (i.e. rolling, sitting up, babbling, and eating)? Y____ N ____

_____
_____.

EDUCATIONAL HISTORY

Name of School/Daycare _____
Types of classes: ___ Regular ___ Inclusion ___ESE ___EDB (Emotionally Disturbed Behavior)
___Other (explain): _____

Special Education Placement: **Yes** **No**
If yes, which services and what is the frequency/duration of each?
____ Occupational Therapy ____ / week for ____ minute sessions
____ Physical Therapy _____ / week for ____ minute sessions
____ Speech Therapy _____ / week for ____ minute sessions
____ Counseling _____/ week for ____ minute sessions

History of:
Academic Problems: **Yes** **No** Academic Strengths: **Yes** **No**
If yes, explain: _____
Has Child been retained? **Yes** **No**
If yes, explain: _____
Behavior Problems: **Yes** **No**
If yes, explain: _____
Educational Evaluations: **Yes** **No**
If yes, explain: _____

SOCIAL HISTORY

Does the child attend extracurricular activities? _____
_____.

In school, how many friends does the child have? _____
_____.

Is the Child able to form and maintain relationships with family/friends? **Yes** **No**

Peer relationships: _____

_____

What are the Child's favorite activities: _____

_____

Hobbies and interests: _____

_____

Does the child have a Girlfriend or Boyfriend: **Yes** **No**

Current problems with close relationships? **Yes** **No**

Describe: _____

Sexually active: **Yes** **No**

Describe: _____

Gang involvement: **Yes** **No**

Describe: _____

LEGAL HISTORY OF CHILD/ADOLESCENT

If history of legal issues, please explain:

_____

_____

Arrest charges pending: **Yes** **No**

Describe: _____

Previous arrests: **Yes** **No**

Describe: _____

Probation: **Yes** **No**

Describe: _____

Court supervision: **Yes** **No**

Describe: _____

Family court/status offenses: **Yes** **No**

Describe: _____

Restitution: **Yes** **No**

Describe: _____

_____/_____ _____

Name of person completing information/relationship to child Date