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Child Background Form

CHILD'S INFORMATION: CHILD'S NAME: _____
AGE: _____ BIRTHDATE:_____ GRADE: _____
TEACHER:_____SCHOOL:_____

PARENT(S)/GUARDIAN(S) INFORMATION:
NAME:_____ DOB: _____AGE:_____
ADDRESS: _____
PHONE (HOME):_____ (WORK): _____ (CELL):_____
EMAIL:_____
OCCUPATION: _____

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ADDRESS: _____
PHONE (HOME):_____ (WORK): _____ (CELL):_____
EMAIL:_____
OCCUPATION: _____

PARENT(S)/GUARDIAN(S) MARITAL STATUS: Single ____Living together ____
Engaged ____ Married ____Separated ____ Divorced ____Remarried ____
Widowed ____ Number of Years married/living together:_____

Were there any previous marriages for either spouse: _____
Additional Info/Duration/Children from previous relationships if applicable:

_____

_____

WHO IS LIVING IN YOUR RESIDENCE? _____

_____

SIBLINGS NOT LIVING AT HOME: _____

WHY YOU'RE HERE:
What is the problem you seek help for? How long has it existed?

Please describe previous experience with counseling including what was helpful and what was not helpful:

FAMILY MENTAL HEALTH HISTORY:
Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (check any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty: Family Member

Depression: □ No □ Yes
Bipolar Disorder: □ No □ Yes
Anxiety Disorders: □ No □ Yes
Panic Attacks: □ No □ Yes
Schizophrenia: □ No □ Yes
Alcohol/Substance Abuse: □ No □ Yes
Eating Disorders: □ No □ Yes
Learning Disabilities: □ No □ Yes
Trauma History: □ No □ Yes
Suicide Attempts: □ No □ Yes

What might contribute to the problem, i.e. the "emotional climate" in the home or community?

DEVELOPMENTAL HISTORY:

Was this a planned pregnancy? _____ Were there any problems during the pregnancy or birth? _____ If yes, what and when?_____

_____ Length of labor: _____ Birth Difficulties: _____

_____

Breast or bottle fed? _____ Any feeding problems during the early years? _____If yes, what? _____

Child's health during first year, including allergies?

_____

_____

_____

_____

When did your child achieve the following milestones:

Talk: _____ Any difficulties?_____

Walk: _____ Any difficulties?_____

Toilet trained: _____ Any difficulties? _____

Relationship with brothers and sisters:

_____

_____

_____

Relationship with friends:

_____

_____

_____

Please describe important developments in your child's background:

_____

_____

_____

Unusual events and/or reactions to events (i.e. prolonged separation from parents, divorce of parents, deaths in family, hospitalization of family member):_____

_____

_____

_____

SCHOOL:
When started school: _____
School performance- academic: _____
_____
_____
School performance- social: _____
_____
_____
Other pertinent information: _____
_____
_____

MEDICAL HISTORY:
Has your child had any medical problems (i.e. accidents, high fevers, childhood diseases, surgery, hospitalization)? _____ If yes, what and when? _____
_____
Child's Physician's Name: _____ Phone:_____
Is your child taking any medications? _____If yes, please list medications and dosages: _____
_____
_____
Medicating Physicians or Psychiatrist: _____ Phone: _____

Name of person filling out form: _____
Relationship to child: _____ Date: _____

In case of an emergency, whom can we notify?

Name: _____ Relationship: _____
Address: _____
Phone: (Home) _____ (Work) _____ (Cell)_____

THANK YOU!