Carolyn Wolfe, LMFT, LLC
105 N Virginia Ave #305
Falls Church, VA 22046
Telephone: (703) 405-9451

Child Background Form

CHILD'S INFORMATION:

CHILD'S NAME: _____ DATE: _____
AGE: _____ BIRTHDATE:_____GRADE:_____
TEACHER:_____SCHOOL:_____
ETHNIC BACKGROUND:_____ RELIGION:_____

PARENT(S) INFORMATION:

MOTHER'S NAME:_____ AGE:_____
ADDRESS: _____
PHONE (HOME):_____ (WORK):_____ (CELL):_____
EMAIL:_____
ETHNIC BACKGROUND:_____ RELIGION:_____
MOTHER'S HIGHEST GRADE OF EDUCATION: _____
MOTHER'S OCCUPATION: _____

FATHER'S NAME:_____ AGE:_____
ADDRESS: _____
PHONE (HOME):_____ (WORK):_____ (CELL):_____
EMAIL:_____
ETHNIC BACKGROUND:_____ RELIGION:_____
FATHER'S HIGHEST GRADE OF EDUCATION: _____
FATHER'S OCCUPATION: _____

PRESENT 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?_____
_____
CHILDREN NOT LIVNG AT HOME: _____
_____

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 _____

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