Child Form Background Information (Please Print)

Date:		
Name: Last	First	MI
		City:
State:	Zip:	
Phone:	(cell)	(home)
Parent email for bi	illing:	
Sex:	Date of Birth:	
School:	Gra	de:
	ncy, who should be notified? Relationship to clie	
Who currently live	es in your home? Please list	· •
Please describe yo	ur child's present concerns	or difficulties.

What would you like to see change for your child as a result of our work in therapy?
Have you sought therapy in the past? If so, please list approximate dates, locations, provider and reason. Please describe how that was/wasn't helpful.
Please list any known mental health and or substance abuse concerns or problems in your family history.
Please list any past or current significant health/medical issues, illnesses, or treatments.
Please list any medications currently taking.

Please help me understand your current and recent symptoms. (Check all that apply, describe in detail at bottom of list).

Appetite/Weight changes Not eating, binge eating or purging General Eating/Body Image concerns **Memory Problems Concentration Problems Crying Episodes Increased Irritability** Depressed Mood (feeling sad/down?) Social Withdrawal Changes in Energy Level Manic Episodes (feeling elevated, needing less sleep, spending...) Panic Attacks Unusual Behaviors/rituals/Habits Obsessive Thoughts Anxiety/Worry Cutting or Self-Injurious Behavior Alcohol/Drug use/abuse Thoughts of Harming Self/Others Past Attempts of Self Harm **Recent Loss** Feeling Excessively Guilty **Recurrent Thoughts of Death** Decreased Interest or Pleasure in Activities Sleep Problems (can't, oversleep, interrupted sleep) Decreased Need for Sleep Feelings of Worthlessness **Difficulty Making Decisions Feeling Restless** Feeling Slowed Down **Racing Thoughts** Distractibility More Talkative/Pressure to keep talking

Are there any other symptoms that are bothering you that I have not asked about here?