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Child/Adolescent Background Information

Identifying Information:

Client Name _____ Birth Date _____ Gender _____

Address _____ Race _____

Phone _____ E-mail _____

Preferred form of contact _____ Where can we leave messages? _____

School District _____ School _____

Grade _____ Educational Supports _____

Family:

Mother's Name _____ Birth Date _____ Race _____

Address *(if different from above)* _____

Phone - Home _____ Cell _____ Work _____

E-mail _____

Preferred form of contact _____ Where can we leave messages? _____

Mother's Occupation _____

Father's Name _____ Birth Date _____ Race _____

Address *(if different from above)* _____

Phone - Home _____ Cell _____ Work _____

E-mail _____

Preferred form of contact _____ Where can we leave messages? _____

Father's Occupation _____

Marital Status of parents _____ **Legal Custody Agreement?** ☐ Yes ☐ No

Visitation schedule *(if applicable)* _____

Additional caregivers involved *(List name, age, and relationship to client)* _____

_____

_____

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Other family members *(List name, age, relationship to client, and place a check next to individuals residing in the home)* _____

_____

_____

_____

Medical History:

Current Medical Condition(s) _____

_____

Allergies _____

Prior Medical Procedures _____

_____

_____

History of Head Injury ☐ Yes ☐ No Loss of Consciousness ☐ Yes ☐ No History of Seizures ☐ Yes ☐ No

Exposure lead/toxic ☐ Yes ☐ No Chronic/Acute Pain ☐ Yes ☐ No

Treatment History:

Primary Care Physician _____

Current Treatment Providers (Mental Health, In-School Services, Developmental Specialists, etc.)

Agency	Date Begun	Contact Person/Title

Current Medication(s)

Name	Dose/Frequency	Prescribing Physician

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Treatment History (Include Mental Health, Psychiatric Hospitalizations, placements, developmental Specialists, etc.)

Agency	Dates	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Community Supports:

Religious Affiliation (optional) _____ Place of Worship _____

Employment Experience (Include Organization and dates) _____

_____

Past and Present Leisure Activities (e.g., sports, clubs, camps, extracurricular activities, etc. Include organization and dates) _____

_____

_____

Please answer the following questions…

1. Any history of mental health concerns in your immediate or extended family? ☐ Yes ☐ No
2. Any history of substance abuse in your immediate or extended family? ☐ Yes ☐ No
3. Any history of legal problems in your immediate or extended family? ☐ Yes ☐ No
4. Any family history of domestic violence? ☐ Yes ☐ No
5. Any history of physical abuse toward the client? ☐ Yes ☐ No
6. Any history of sexual abuse toward the client? ☐ Yes ☐ No
7. Any history of neglect of the client? ☐ Yes ☐ No

If you answered "yes" to any of these questions, please provide details: _____

_____

_____

Are there topics that you would like to discuss with the therapist today, without your child present? ☐ Yes ☐ No

If so, provide brief description of topic(s) _____

_____

_____ _____ _____

Signature of Individual Completing Form | Printed Name and Relation to Client | Date