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## Child/Adolescent Background Information

**Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.**

Child's Name: _____ Date of First Visit _____

Completed by:_____ Relationship to Child: _____

Home Phone:_____ (**May call**: yes__no__ **May Leave Message**: yes__ no__)

Work Phone:_____ (**May call**: yes__no__ **May Leave Message**: yes__ no__)

Best Time and Place to call: _____

Child's Address: _____

Child's Gender: Male___ Female___ Date of Birth___ Age _____

Child's Ethnicity: Caucasian___ Africa American___ Hispanic/Latin___ Asian___ Native American___ Bi-racial___ other (explain) _____

In case of emergency, contact: _____
Name Relationship Phone

Has your child ever seen a mental health professional (psychiatrist, psychologist, etc)? No___ Yes__

Previous Mental Health Professional/Agency_____
Name Address

Who referred you to our clinic? May we have his/her name?_____

Person responsible for financial arrangements with our clinic:_____
(**Dr. Valdez is an out-of- network provider for all insurance companies**.)

*** INFORMATION ON CHILD'S MOTHER ***

**Mother's Name:**_____

I am: ___ biological mother ___stepmother ___adopted mother other _____

Address: _____

Home Phone:_____ Work Phone: _____
(May call: Yes/no Leave Message: Yes/No) (May call: Yes/no Leave Message: Yes/No)

Date of Birth:_____ Occupation: _____

Employer_____ How Long:_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married _____ Separated _____ Divorced _____ Widowed _____

*** INFORMATION ON CHILD'S FATHER ***

**Father's Name:** _____

I am: __ biological father ___stepfather ___adopted father other _____

Address: _____

Home Phone: _____ Work Phone: _____
(May call: Yes/no Leave Message: Yes/No) (May call: Yes/no Leave Message: Yes/No)
Date of Birth:_____ Occupation: _____

Employer:_____ How long:_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married _____ Separated _____ Divorced _____ Widowed _____

*** GENERAL INFORMATION ***

Child's current household: Mother only ___ Father only ___ Natural parents ___ Natural Mother and Step-Father ___ Natural Father and Step-Mother ___ Blended family (both spouses with children) ___ Adoptive parents __ Grandparents___ Other Relatives __ Foster family __ Institution __ Other_____

List by Household your child's current family, beginning with the oldest member and include the child:

**Primary Household** (anyone who currently lives with child)
**How long in this current living situation:** _____

| Name | Age | Gender | Relationship to you (include "step", "half", etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Child lives in**: House_____ Apartment ____ Duplex _____ Other_____

**Second Household** (non-custodial or extended family - if applicable)

| Name | Age | Gender | Relationship to you (include "step", "half", etc.) |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

Currently involved in a custody dispute: No __ Yes __ (If yes, explain) _____

_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly
__1_____2_____3_____4_____5

How often does client see non-custodial parent? _____

## * CHILD'S HEALTH *

Child's Primary Care Physician: _____
Name Phone

_____
Address

Date of LAST complete physical_____

Has your child ever seen a psychiatrist? Yes___ No___
Is child currently seeing a psychiatrist? Yes___ No___ (If yes list name and address and phone):

_____
Name Address Phone

Physical Disability: Yes __ No ___ (If yes, explain) _____

Chronic Illness: Yes ___ No ___ (If yes, explain) _____

Terminal Illness: Yes ___ No ___ (If yes, explain) _____

Check the following items for a diagnosis or medication that your child is now receiving or has received:

| **Diagnosis** | **Current** | **Past** | **Date of Diagnosis** | **Name of medication** | **Dosage** |
|---|---|---|---|---|---|
| Depression | | | | | |
| ADHD Hyperactive | | | | | |
| ADHD Inattentive | | | | | |
| Conduct Disorder | | | | | |
| Learning Disability | | | | | |
| Anxiety/ Nervousness | | | | | |
| Panic Attack | | | | | |
| Manic-Depression (Bipolar) | | | | | |
| Schizophrenia | | | | | |
| Oppositional Defiant Disorder | | | | | |
| Mood/Anger | | | | | |
| Tics | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Insomnia/ Sleeplessness | _____ | _____ | _____ | _____ | _____ |
| Obsessive/ Compulsive | _____ | _____ | _____ | _____ | _____ |
| Addictions | _____ | _____ | _____ | _____ | _____ |
| Convulsions | _____ | _____ | _____ | _____ | _____ |
| Post-Traumatic Stress Disorder | _____ | _____ | _____ | _____ | _____ |
| Other | _____ | _____ | _____ | _____ | _____ |

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If your child has been diagnosed, who gave the diagnosis? Pediatrician____ Psychiatrist___ School____

Other _____

What other medication is your child currently taking?

| Medication | Dosage | Taken for what reason? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

## * CURRENT CONCERNS *

**Indicate severity of up to 10 items that currently apply to your child. (1-mild; 2-moderate; 3-severe) <u>Circle the item that you see as the most significant issue</u>)**

__Adjustment to life changes (changing schools, parent's divorcing, moving, etc.)
___Bed wetting daytime wetting, soiling or related problems
___Career Decisions
___Abuse (physical, emotional, sexual)
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling angry or irritable
___Feeling guilty or shameful
___Feeling sadness or depression <u>related to grief</u>
___Feeling sadness or depression <u>NOT related to grief</u>
___Gang related concerns (explain_____)
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
___Learning/Academic difficulties
___Personal Growth (no specific problem)
___Parent-Child relationship (discipline, adoption, single parent, etc.)
___Family or Step-family relationship problems
___Non-family relationship problems (teachers, peers, etc.)
___Religious or Spiritual concerns
___Sexual concerns (excessive masturbation, inappropriate acting out)

___Sexual identity concern
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Suicidal Ideation (thoughts of death, wanting to die)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Other (explain_____)
***Remember to circle the most significant issue.**

When did you first become concerned about this issue?_____

How have you attempted before now to deal with these issues? _____

_____

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

Anything else you think we need to know_____

What is the one thing I need to know to help your child today? _____

*** FAMILY HISTORY/EXPERIENCES ***

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

Raised by: Natural parents___ Single natural parent___ Grandparents___ Adoptive parent(s)___ Natural and step-parent___ Foster parents___ Institution___ Relatives___ Other_____

Stressors in the Family: Parents fighting frequently___ Parents divorced___ Financial problems___ Family member's disability or major accident or illness___ Chronic illness of family member___ Moved a lot___ Family member absent (explain)_____ Death of significant person___ Family member suicide(explain)_____
Family member emotional problems (explain) _____
other (explain) _____

History of your child having learning, emotional, behavioral problems: yes__ no__
(If yes, please explain) _____

History of family violence: yes__ no__
(If yes, please explain) _____

Has your child been abused (check all that apply): Physically___ Emotionally___ Sexually___

Has your child been neglected (check all that apply): Physically___ Emotionally___

School Problems (check all that apply): Academic problems___ Severely teased___ Discipline problems___ Unpopular___ other (explain_____)

History of anxiety symptoms include: (indicate all that apply): Obsessive worrying ___ Keyed up, on edge ___ Phobias ___ Irritable ___ Physical symptoms (below) ___ other _____

History of health/physical problems include: (check all that apply): Headache (kind) ___ Nervous stomach ___ Diarrhea ___ Bone/joint/muscle ___ PMS ___ Dizziness ___ Shortness of breath without exertion ___Heart

Palpitations ___ Chest pain ___ Surgeries ___ Major illness___ Major accident___ Disability___ Chronic illness___ Hospitalization___ Developmental delay(s)___ Sleep problem___ Bedwetting___ Serious overeating or undereating___ Neurological problems/exam___ Asthma___ Other_____

History of trauma/stressor include: (check all that apply): Child separated from parent (how long and when)_____ Death of a significant person___ Death of a pet___ Incarcerated family member___ Sexual Assault___ Victim of trauma (unusual, terrifying experience)___ Medical___ Natural Disaster___ Other _____

History of interpersonal problems include: (check all that apply): Frequent arguments___ Taken advantage of___ Temper outbursts___ aggressive behavior___ Loner___ Other_____

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Family Atmosphere (circle the number that best describes how you view your child's current family atmosphere)

| | | | | | | |
|---|---|---|---|---|---|---|
| Very lenient | 1 | 2 | 3 | 4 | 5 | Very strict |
| Very non-religious | 1 | 2 | 3 | 4 | 5 | Very religious |
| Chaotic | 1 | 2 | 3 | 4 | 5 | Highly structured |
| Few expectations | 1 | 2 | 3 | 4 | 5 | High expectations |
| Inconsistent | 1 | 2 | 3 | 4 | 5 | Consistent |

Family Support System (such as church, friends, relatives, school)

| | | | | | | |
|---|---|---|---|---|---|---|
| Hardly any support | 1 | 2 | 3 | 4 | 5 | Considerable support |

Your child's current use of Computer, VCR, and Television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+