

Child's Name: \_\_\_\_\_ Child's Age: \_\_\_\_\_ ID #: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Check all the problems this child is having or has had by placing an "X" in the "Current" and/or "Past" column.

	Current	Past
Gets angry easily		
Temper tantrums		
Yells and screams		
Hits children or adults		
Throws/breaks things		
Threatens to hurt others		
Shows no respect; argues		
Gets into a lot of fights		
Won't follow rules/do chores		
Won't do what adults say to do		
Lies		
Steals		
Cheats		
Is never sorry		
Sets fires		
Hurts animals		
Skips/doesn't want to go to school		
Runs away		
Has friends who are a bad influence		
Problems making/keeping friends		
Worries a lot/nervous		
Sad/depressed		
Quick changes in mood		
Hard time falling asleep		
Sleeps during the day		
Won't sleep in own bed		
Nightmares		
Afraid/fearful		
Irritable		
Problems being away from caregiver		
Stays away from people, friends, or activities		
Shy		
Low self-esteem		
Lots of headaches or stomach aches		
Overeating		
Loss of appetite		
Doesn't keep self clean/won't bathe		
Recent weight loss		
Recent weight gain		
Eats a lot in a short amount of time		

	Current	Past
Forces self to vomit		
Tobacco use		
Drug or alcohol use		
Sexually active		
Masturbates		
Acts in a sexual way that is not appropriate		
Gang member		
Does things in secret/hides		
Does things that are dangerous		
Acts before thinking		
Pays attention for only a short time		
Hard time concentrating		
Forgets things		
Unable to sit still		
Overactive		
Underactive		
Keeps to him/herself		
Has imaginary friends		
Doesn't trust others		
Too trusting of others		
Can't take mind off one subject		
Likes order and routine		
Twitches, jerks, or shakes		
Grinds teeth		
Sucks thumb		
Bites nails		
Picks skin		
Hits self		
Bangs head		
Hurts/cuts self		
Below average intelligence		
Problems with talking/speech		
Grunts, barks, snorts, or growls		
Wets pants/clothes		
Wets bed		
Soils clothes		
Smears feces		
Hears voices that are not there		
Sees things that are not there		
Other:		

Does this child have thoughts of hurting herself/himself or others?  No  Yes - If Yes, when and how?

\_\_\_\_\_

Has this child attempted to hurt herself/himself or others?  No  Yes - If Yes, when and how?

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Why do you think this child is having these problems? \_\_\_\_\_

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Have there been new changes or pressures in your or this child's life?  No  Yes \_\_\_\_\_

If yes, explain: \_\_\_\_\_

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What do you want this child to gain from treatment? \_\_\_\_\_

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Does this child have any (physical, learning, or thinking disability, limitation, or impairment) that may tell us if he/she can be an active part of treatment?  No  Yes If Yes, explain: \_\_\_\_\_

What strengths does this child have? \_\_\_\_\_

**PRENATAL AND BIRTH HISTORY**

Mother's age at child's birth: \_\_\_\_\_

During pregnancy was there any use of:  Tobacco  Alcohol Other drug(s): \_\_\_\_\_

Prescription medication: \_\_\_\_\_

Check if any of the following happened during pregnancy:  Vomiting  Spotting  Kidney trouble

Excess swelling  High blood pressure Other \_\_\_\_\_

Was the pregnancy full term?  Yes  No # of weeks: \_\_\_\_\_ Birth weight: \_\_\_\_\_

Check if any of the following happened:

C-Section  Breech birth  Jaundice  Use of delivery instruments (for example, forceps)

Other problems \_\_\_\_\_

Tell about any feelings of depression (sadness) the mother had during pregnancy and/or after delivery:

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**INFANT AND TODDLER HISTORY**

Tell about the way this child acted from birth to age 2: \_\_\_\_\_

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Tell about the way this child acted from ages 2 to 5: \_\_\_\_\_

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As an infant or young child, check if he/she had problems with:

- Becoming attached to parent/caregiver
- Being away from caregiver
- Energy
- Growth
- Asthma
- Allergies
- Vomiting
- Fever
- Colic
- Diarrhea
- Constipation
- Sleep
- Seizures
- Eating
- Other: \_\_\_\_\_

At what age did this child: Walk \_\_\_\_\_ Speak single words \_\_\_\_\_ Speak sentences \_\_\_\_\_

Become toilet trained: Daytime \_\_\_\_\_ Nighttime \_\_\_\_\_

If there were/are problems with any of these, what were they? \_\_\_\_\_

**FAMILY INFORMATION**

Child raised by: \_\_\_\_\_

List other adults who are important to this child: \_\_\_\_\_

Is this child adopted?  No  Yes If Yes, does this child know?  No  Yes

If parents are separated/divorced/or never married - parent custody/visitation arrangements\*: \_\_\_\_\_

\*A copy of the court guardianship/custody legal papers are necessary for our file in separation/divorce cases.

Which parent knows that this child may be treated here?  Mother  Father

Has this child ever been in foster care?  No  Yes - If Yes, when and why? \_\_\_\_\_

Has this child/family ever been seen or talked to by someone at DHS?  No  Yes If yes, explain: \_\_\_\_\_

Has Protective Services ever talked with or seen this child or this child's family?  No  Yes

If Yes, when and why? \_\_\_\_\_

Describe any violence, physical abuse, or sexual abuse that the child has seen, heard, been a part of, or had happen to him/her:

None \_\_\_\_\_

Do you/family member/guardian have any sexual or gender (boy/girl) concerns about this child?  No  Yes

If yes, why? \_\_\_\_\_

Is there anything going on in the family that may be affecting this child at this time?  None \_\_\_\_\_

List this child's relatives with mental health and/or substance abuse problems: \_\_\_\_\_

Annual Household Income: \$ \_\_\_\_\_

Sources of Income:  Employment  DHS/Public Assistance  Social Security or Disability  
 Child Support/Alimony  Retirement Other: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_  Unemployed

Mother's Occupation: \_\_\_\_\_  Unemployed

Do you/family currently have money problems?  No  Yes If Yes, explain: \_\_\_\_\_

How is this child disciplined?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Other: \_\_\_\_\_

Tell us about this child's religious/spiritual upbringing: \_\_\_\_\_

Tell about your family's ethnic background (traditions, language, holidays): \_\_\_\_\_

**EDUCATIONAL/SCHOOL HISTORY**

Has this child gone to:  Preschool  Day Care  Latch Key Program

Has this child been diagnosed as having learning problems (learning disabled, emotionally impaired, or mentally retarded)?  No  Yes If Yes, please describe:

Has this child had any psychological testing done at school or at another clinic?  No  Yes

If Yes, where? \_\_\_\_\_ when? \_\_\_\_\_

Do you know if a diagnosis or name of a condition was given to this child by a doctor, psychologist, or social worker?  No  Yes

If Yes, what was it? \_\_\_\_\_

How are the child's grades in school?

Unsatisfactory  Satisfactory  Passing Mostly:  A  B  C  D  Failing

Tell about any school problems (attendance, suspensions, behavior, not completing homework, failing a grade): \_\_\_\_\_

Fill in the names and cities of all schools this child has gone to:

Elementary School \_\_\_\_\_

Middle School \_\_\_\_\_

High School \_\_\_\_\_

How many friends does this child have? \_\_\_\_\_ Are the child's friends:  Same age  Older  Younger  
Is it hard for this child to make or keep friends?  No  Yes If Yes, why: \_\_\_\_\_

Father's Educational Level:  Post College/Advance Degree  College Graduate  
 High School Graduate  Some High School  8<sup>th</sup> Grade or Less

Mother's Educational Level:  Post College/Advance Degree  College Graduate  
 High School Graduate  Some High School  8<sup>th</sup> Grade or Less

**TREATMENT/COUNSELING HISTORY**

Has this child ever met with a social worker at school?  No  Yes If Yes, when? \_\_\_\_\_

Has this child ever been in treatment for mental health or substance abuse problems?  No  Yes

If yes, please list where, when, reason, and if it helped:

Where	When	Reason	Helpful?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Any other comments you would like to make about this child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Custodial) Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature and Credentials of Therapist reviewing this form

\_\_\_\_\_  
Date