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Child Background History

Name of Child	
Mother's Name	
Father's Name	
Guardian's Names (if different)	
Who completed this form?	
Birthdate	
Date of Initial Appointment	
School	
Grade	
Gender	
Ethnicity	
Languages spoken at home	

Which behaviors is your child struggling with most?

What are your child's strengths?

Please describe any life changes that could be affecting your child:

Social History:

Please list places your child has lived: Child's birthplace: _____

Location	Dates or Ages

Please list your child's siblings:

Name	Age/Grade	Learning problems?		Mental Health difficulties	
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No
		Yes	No	Yes	No

Who currently lives in the family home?

Are the child's parents married? Yes No

If No, are they divorced or separated? Yes Never Married

If divorced or separated please describe current parenting plan?

Parent Time with Father: Frequency:_____Length of Visits:_____

Parent Time with Mother Frequency:_____Length of Visits:_____

Please describe the relationship status of both parents?
Relationship with Father: N/A Poor Fair Good
Relationship with Mother: N/A Poor Fair Good
Biological Father's Job:_____ Biological Mother's Job:_____

Does the child have step-parents? Yes No Names:_____

Step-Father's Job:_____ Step-Mother's Job:_____

Does your child attend a religious organization regularly? Yes No Where_____
Do any close family/friends in the area to provide support to your family and child? Yes No
Has your child ever been in trouble with the law? Yes No
If so, please list offenses and outcome
Who is in charge of discipline in the home?
Do all caregivers agree on discipline procedures in the home? Yes No
Describe discipline strategies that are used:

History of Trauma (circle all that apply):

Serious Illness in Family	Sexual Abuse	Victim of Violence
Serious Illness in Child	Exposure to Domestic Violence	Unsafe Neighborhood
Poverty	Child Abuse/Neglect	Homeless
Other traumatic events:		

Have the child's parents or guardians ever been on probation? Yes No
Served time in jail or prison? Yes No
Has the Department of Children & Families (DCF) ever been involved with your family? Yes No
Explain:

Has the child ever been placed outside of his/her home? Yes No
Explain:

Has the child ever been involved with Juvenile Services? Yes No
Explain:

Please circle any of the following mental health symptoms that your child often struggles with:

Irritable	Excessively sad	Excessively nervous	Difficulty separating from parents
Poor attention to detail	Paying attention for long periods	Poor organization	Easily distracted
Does not listen when spoken to directly	Fails to finish work	Often loses things	Forgetful
Loss of interest in normally enjoyable activities	Refuses to attend school	Frequent mood changes	Purposefully injuries self
Mistrustful	Defiant	Low self-esteem	Sleeps with parents
Test anxiety	Impulsive	Social anxiety	Strong beliefs that are unsupported by reality
Sees or hears things that are not present	Talks about suicide	Unemotional	Obsessions
Lack of remorse	Suicide attempt	Phobia with _____	
Fidgets	Restless	Physical aggression	Verbal aggression
Argues with adults	Cruel to animals	Steals	Hyper
Sexually inappropriate	Trespassing	Interrupts others	Leaves house without parent permission
Runs away from home	Talks excessively	Difficulty remaining quiet	Hostile

Excess spending	Takes risks	Ritual/routine behavior	Overly dramatic

Circle any of the following harmful eating behaviors that your child struggles with:

Refuses to eat in front of others	Induces vomiting after meals	Overly restrictive diet	Exercises right after meals
Uses diuretics	Purposefully fasts	Binge eats	Overly picky eater

Circle any of the following social skills which are difficult for your child:

Eye contact when not in trouble	Does not initiate interactions with peers	Lack of desire to share enjoyment in activities	Does not understand give and take of social relationships
Lacks empathy	Lack of age-appropriate pretend/make believe	Accepting criticism	Bossy
Inappropriate comments	Does not take turns	Does not share	Bragging
Sustaining conversations	Overly shy	Inflexible with routines/rules	Difficulty adjusting to change

Circle any communication difficulties which affect your child:

Not using eye contact to interact with others	Problems reading facial expressions	Using nonverbal signals to convey meaning	Difficulty expressing self effectively
Stutters	Facial expressions don't match emotion	Speaks in an odd voice	Speaks too loud
Speaks too soft	Invades personal space	Difficulty with pronunciation	Verbal tics
Does not speak in everyday situations	Unusual rate of speech	Uses words that have no meaning	Curses excessively

Circle any sensory difficulties that your child struggles with:

Waves hands in front of face	Refuses to eat foods with certain textures	Rocks while seated	Twisting or ringing hands
Looks at things too closely	Often looks at things out of the corner of their eye	Overly sensitive to loud noises	Under-responsive to loud noises
Motor tics	Refuses to wear certain fabrics	Only eats certain foods	Preoccupied with lights or parts of objects

Developmental History:

Was your child's pregnancy normal? Yes No

If no, explain complication?

Was your child's delivery normal? Yes No

If no, explain complication?

Premature	Low Birth Weight	Gestational Diabetes	Jaundice
C-Section	Mom drank alcohol	Mom smoked	Mom used illegal drugs

Number of days in hospital following birth?_____

Infant Temperament (circle all that apply): Easy to Soothe Happy
Under-responsive Fussy Difficult to Soothe Withdrawn

When did your child reach the following developmental milestones?

First Words: _____ First Steps:_____ Toilet training:_____

Describe any unusual development:

Is your child's vision normal? Yes No If not, what type of corrective lenses do they use?

Is your child's hearing normal? Yes No If not, what type of corrective device do they use?

Place an "X" next to any medical diagnosis that your child has received:

Medical Disorder	Birth to age 12	As an adolescent
Failure to Thrive		
Chronic Ear Infections		
Lead Poisoning		
Cancer		
HIV/AIDS		
Concussion		
Seizure/Epilepsy		
Digestion Issues		
Broken Bones		
Chronic Stomach Problems		
Asthma		
Meningitis		
Head Injury		
Other Illness_____		

Circle any of the following that have been present with your child's **family members**:

Heart Disease/Attack	Stroke	Cancer	Intellectual Disability/MR
Learning Problems	ADHD/Attention Problems	Anxiety	Depression
Social Difficulties	Autism/Asperger's	Bipolar Disorder	Obsessive-Compulsive
Personality Disorders	Schizophrenia	Conduct Disorder	Oppositional Defiant Disorder
Suicide	Extended Unemployment	Alcoholism	Drug Addiction/Abuse
Jail/Prison	Probation/Parole	Other	

Circle or list any diagnoses **your child** has been given: _____ None

Learning Disability/Problems	Developmental Disabilities	Intellectual Disability/MR	ADHD
Autism/Asperger's	Anxiety	Obsessive Compulsive Disorder	Schizophrenia
Depression	Bipolar Disorder	Oppositional Defiant Disorder	Conduct Disorder
Other			

Please list any current medications:_____
_____
Please list any previous medications:_____
_____

History of Treatment Services:

Practitioner	*Name/Organization*	*Dates*	*Treatment/Duration*
Psychiatrist			
Pediatric Neurologist			
Occupational Therapist			
Speech Therapist			

Physical Therapist			
Mental Health Services	1. 2. 3.		
Other Specialists:			

Has your child ever been hospitalized? Yes No
If so, what happened and when?

Circle any of the following that your child often struggles with:

Headaches	Fainting	Sleeps too little	Sleeps too much
Seizures	Nausea	Eats too much	Eats too little
Stomachaches	Vomiting	Diarrhea	Constipation
Heart racing	Chest pains	Excess sweating	Shallow breathing
Tension	Sore throat	Bed wetting	Bed soiling
Hair pulling	Nail biting	Wets self	Soils self

Circle any motor difficulties that your child has/had:

Clumsiness	Awkward gait	Difficulty skipping	Difficulty learning to ride a bike
Not athletic	Poor Fine Motor	Difficulty coordinating movements	Difficulty throwing or catching

Educational History:

Did your child attend Preschool? Yes No If so, where?_____
What is your child's current grade? _____
Please list your child's schools:

School	City and State	Age or Grade

Circle how well your student typically does in each of the following subjects:

Math	D or F	C	B	A
Language Arts	D or F	C	B	A
Social Studies	D or F	C	B	A
Science	D or F	C	B	A
Art	D or F	C	B	A
Gym/PE	D or F	C	B	A
Other:				

Circle any of the following which have been problematic for your child over the past year:

Off-task behavior in class	Victim of bullying	Poor School Attendance	Detention
Not doing HW	Bullying others	Several Changes of School	Suspension
Failing grades	Physical fights	Alcohol	Expulsion
School/Test Anxiety	Skipping school	Cigarettes	
Conflict w/teachers	School refusal	Drugs	

Has your child ever been retained in or repeated a grade? YesNo If so, what grade(s)?____

Does your child have an individual education plan (IEP)? Yes No

If so, circle all classifications that apply:

Reading learning disability	Math learning disability	Writing learning disability	Speech impaired
Hearing impaired	Visually impaired	Emotional disturbance	Mental retardation
Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other
Fine Motor Difficulties	Gross Motor Difficulties		

Does your child have a 504 plan? Yes No

If so, what is the child's disability?

What special services or accommodations do they receive at School (mark all that apply)?

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments
Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

Has your child started the Response to Intervention process? Yes No

If so, which tier is he/she in? Tier I Tier II Tier III

What current intervention is being used?

In which after school activities does your child participate?

Does your child make and maintain friendships easily? Yes No

If no, please explain:

Quality of Relationships with Peers: Poor Fair Good

Number of close friends: _____

How often does your child spend time with them outside of school?_____

Future Educational/Career Goals:_____

<u>If Applicable, complete:</u>

Is your son/daughter dating? Yes No

Is your child sexually active? Yes No Don't Know

To the best of your knowledge, has/does your child use any of the following? _____ None

Alcohol, PCP (angel dust), marijuana, amphetamines (speed), cocaine, crack cocaine, hallucinogens (acid, mushrooms), ecstasy, methamphetamine (meth), opium, heroin, sleeping pills, pain killers

Last used:_____