Mental Health Background Information

DEMOGRAPHICS:

Name of the person completing this form:

Relationship to the child:

Child’s Full Legal Name:

Is there another name the child prefers being called?

Child’s Date of Birth: / /

Age:

Gender:

Race:

Religion:

|  |  |  |
| --- | --- | --- |
| Is the child adopted? | No | Yes |
| If yes, are they aware? | No | Yes |

Who lives in the same household as the child?

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Sex | Age | Relationship to Child |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

What are the main concerns that you have about your child’s behavior or emotions?

How long have you had these concerns?

Traumatic experiences: Has your child ever been exposed to actual or threatened death, serious injury, or sexual violence? No Yes

Please list any symptoms related to the traumatic event?

PAST PSYCHIATRIC HISTORY:

Has your child ever seen a **psychiatrist or therapist/counselor** before?

|  |  |  |
| --- | --- | --- |
| Name of provider | Dates seen | Reason |
|  |  |  |
|  |  |  |
|  |  |  |

Has your child ever been admitted to a **psychiatric hospital**?

|  |  |  |
| --- | --- | --- |
| Name of the hospital | Dates | Reason |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Has your child ever attempted suicide? No Yes If yes, please describe:

Does your child engage in any self-harm behaviors (like cutting)? No Yes If yes, please describe:

Has your child ever been violent or aggressive? No Yes If yes, please describe: FAMILY HISTORY:

Please list any known psychiatric illnesses in **blood relatives** of the child:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Psychiatric illness: | Child’s Mother | Child’s Father | Child’s siblings | Mother’s side of the family | Father’s side of the family |
| Depression |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Bipolar disorder |  |  |  |  |  |
| Psychosis |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |
| ADHD |  |  |  |  |  |
| Intellectual disability or learning problems |  |  |  |  |  |
| Autism |  |  |  |  |  |
| Eating disorder |  |  |  |  |  |
| Alcohol problems |  |  |  |  |  |
| Drug problems |  |  |  |  |  |
| Suicide |  |  |  |  |  |

SUBSTANCE USE HISTORY:

Does the child use: Alcohol Tobacco Illegal drugs Specify:

MEDICAL HISTORY:

Does your child have any history of the following medical conditions *(circle all that apply)*?

|  |
| --- |
| Allergies (describe) |
| Asthma |
| Respiratory Illness |
| Diabetes |
| Convulsions/Seizures/Epilepsy |
| Head Injury |
| Dizziness or Fainting |

|  |
| --- |
| Loss of Consciousness |
| Heart problems |
| High Blood Pressure |
| Low Blood Pressure |
| Urogenital Problems |
| Vision Problems |
| Hearing problems |

List any other serious illness or disease

Has your child ever had surgery? No Yes If yes, describe and give dates:

Has your child ever had any serious injuries? No Yes If yes, describe and give dates:

Biological females only:

Has your child started menstruation? No Yes If yes, at what age

Are periods regular? No Yes

MEDICATIONS:

Please list all medication your child is **currently taking**:

|  |  |  |
| --- | --- | --- |
| Name of medication | Dose of medication | Who prescribes it? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list any medications your child has **taken in the past**:

ALLERGIES: No Known Drug Allergies Other:

Please list any allergies:

SOCIAL HISTORY:

Name of current school: Current grade: Did the child repeat any grades? No Yes Does the child have a 504 plan or IEP? No Yes Is the child in ESE or special needs classes? No Yes

Who all lives together in the household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEVELOPMENTAL HISTORY:

Has anything significant occur during the child’s development years?

TESTING HISTORY:

Any history of IQ or achievement testing? No Yes Ever been tested for hearing abnormalities? No Yes Ever been tested for speech/ language abnormalities? No Yes Has the child ever received occupational or physical therapy? No Yes

OTHER: Has the child experienced any of the difficulties below? Please circle all that apply:

Death of a parent, Death of other loved ones/close friend, Separation from parent or family, Parent separation/divorce, Loss of Home, Family financial problems, Parent with substance abuse problem, Conflicts with parents, Removal of child from home, Victim of crime or violence, Unwanted pregnancy, School problems, Illness in self, Illness in family (specify), Other:

Please elaborate on any of the above and how they have affected our child: