Mental Health Background Information

DEMOGRAPHICS:

Name of the person completing this form:	
Relationship to the child:	
Phone #:	Email:
Child's full legal name:	
Child prefers being called:	
Child's Date of Birth:	Age:
Gender:	Race:
Ethnicity:	Religion:
Child's Primary Care Provider:	

Please list who lives in the same household as the child:

Name	Sex	Age	Relationship to Child

PSYCHIATRIC HISTORY:

What are the main concerns that you have about the child's behavior or emotions?			
How long have you had these concerns?			
	No	Yes	Please describe/specify:
Has the child ever attempted suicide?			
Does the child engage in any self-harm behaviors (like cutting)?			
Has the child ever been violent?			
Has the child ever been aggressive?			
Does the child use alcohol?			
Does the child use tobacco or vape?			
Does the child use illegal drugs?			

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

Name of provider	Dates seen	Reason

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

Name of the hospital	Dates	Reason

FAMILY HISTORY:

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

	Child's Mother	Child's Father	Child's siblings	Mother's side of the family	Father's side of the family
Anxiety					
Attention-deficit/hyperactivity disorder (ADHD)					
Autism					
Bipolar disorder					
Depression					
Eating disorder					
Intellectual disability or learning problems					
Psychosis					
Schizophrenia					
Substance/alcohol/drug misuse					
Suicide					

MEDICAL HISTORY:

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

Allergies (describe)		Head Injury	
Asthma		Hearing Problems	
Blood Pressure – High		Heart Problems	
Blood Pressure – Low		Loss of Consciousness	
Convulsions/Seizures/Epilepsy		Respiratory Illness	
Diabetes		Urogenital Problems	
Dizziness or Fainting		Vision Problems	

Please list any other serious illness or disease:
If your child has had surgery, please describe and give dates:
If your child has had any serious injuries, please describe and give dates:
Biological females only, if your child has started menstruation, at what age?
Are periods regular?

MEDICATIONS:

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

Name of medication	Dose of medication	Who prescribes it?
Please list any medications the child has **taken in the past**:		
Please list any drug allergies:		

SOCIAL HISTORY:

Name of current school:	
Current grade:	Did the child repeat any grades?
Does the child have a 504 plan or IEP?	Is the child in ESE or special needs classes?
Please list any school problems (behavioral or academic):	

DEVELOPMENTAL HISTORY:

Has anything significant occurred during the child's development years? (delays, not meeting milestones, etc.)

TESTING HISTORY:

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

OTHER:

Has the child experienced…	No	Yes	Please describe/specify:
Adoption			Are they aware?
Conflicts with parents			
Death of a parent, loved one, close friend			
Family financial problems			
Foster care/removal of child from home			
Illness in family			
Loss of home			
Other separation from parent/family			
Parent separation/divorce			
Unwanted pregnancy			
Victim of crime or violence			
Other:			
Please elaborate on any of the above and how they have affected the child, any symptoms as a result:			