**Today’s Date**: Person Completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Name**: Date of Birth: Age:

**Mother/Legal Guardian 1**

Name: Relationship: Age:

Phone 1: Phone 2:

Address: City: State: ZIP:

Occupation: Employer:

**Father/Legal Guardian 2/Secondary Caregiver**

Name: Relationship: Age:

Phone 1: Phone 2:

Address: City: State: ZIP:

Occupation: Employer:

**Step-Parent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Siblings (names and ages): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_**

Where is the child’s primary residence? List all others living in home (first name, age, relationship to child):

**Presenting Problem:**

**What prompted you to bring in your child at this time**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**About how long has this problem been going on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Describe the circumstance that brings you in at this time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Educational History:**

**Current School**: Grade: Attending Since:

Teacher or primary school contact name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Schools: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concerns at school:

Does the child have any of the following? IEP 504 Plan CSI Team Other

Does the child see a counselor or social worker at school? Yes No

Name:

**Medical History:**

Who is your child’s primary care physician? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want your child’s physician informed that he or she has begun treatment? Yes No

**Current Medications**

Name How Much/How Often Prescribed By Purpose

Known allergies:

Has your child ever been hospitalized? Yes No Reason and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child currently being treated for any medical condition? Yes No

Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History:**

Were there any complications during pregnancy? Yes No

Did your child meet developmental milestones such as sitting, walking and talking at average times? Yes No

Has your child ever needed physical, occupational or speech therapy? Yes No

Please further explain any responses as needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**:

Does anyone in the child’s biological or adoptive family have a history of:

alcohol or drug use? Yes No Explain:\_\_\_\_\_\_\_\_\_\_\_

being incarcerated or on probation? Yes No Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

medical or mental health concerns? Yes No Explain : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

past mental health treatment? Yes No Provide (provider/facility/approximate dates): \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional information about your child:**

What are some of the strengths/skills your child already has?

How do you hope we can help your child?

Does your child get along with kids his or her own age? Yes No Sometimes

Does your child get along well with adults (teachers and relatives)? Yes No Sometimes

Has your child experienced too much yelling or fighing at home? Yes No Sometimes

Has your child talked about harming or killing him or herself? Yes No In the distant past

Please let us know anything else that you feel is important for us to know about your child or your family:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please check those behaviors that apply to your child:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Fidgets | |  | | | | | | |  | | |  | | |  | | | | | \_\_\_\_\_ Cruel to animals | | | | | | | | | | | | | |  | | | | | |
| \_\_\_\_\_ Difficulty remaining seated | | | | | | | | |  | | | | |  | | | | |  | \_\_\_\_\_ Forced someone into sexual activity | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Easily distracted | | | | | | | | |  | | | | |  | | | | |  | \_\_\_\_\_ Used a weapon in a fight | | | | | | | | | |  | | | | | | | |
| \_\_\_\_\_ Difficulty waiting to take turns | | | | | | | | | | | | | |  | | | | |  | \_\_\_\_\_ Often initiates physical fights | | | | | | | | | | |
| \_\_\_\_\_ Often blurts out answers at school | | | | | | | | | | | | | |  | | | | |  | \_\_\_\_\_ Physically cruel to people | | | | | | |  | | | |
| \_\_\_\_\_ Difficulty following directions | | | | | | | | | | | | | |  | | | | |  | \_\_\_\_\_ Often argues with adults | | | | | | |  | | | |
| \_\_\_\_\_ Difficulty sustaining attention | | | | | | | | | | | | | |  | | | | |  | \_\_\_\_\_ Defiant | | |  | | | |  | | | |
| \_\_\_\_\_ Shifts from one activity to another | | | | | | | | | | | | | |  | | | | |  | \_\_\_\_\_ Often annoys others | | | | | | |  | | | |
| \_\_\_\_\_ Difficulty playing quietly | | | | | | | | | | | |  | |  | | | | |  | \_\_\_\_\_ Blames others for own mistakes | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Often talks excessively | | | | | | | | | | | |  | |  | | | | |  | \_\_\_\_\_ Often angry or resentful | | | | | | | | | |  | | | | | | | |
| \_\_\_\_\_ Often interrupts | | | | | | | | | | | |  | |  | | | | |  | \_\_\_\_\_ Swears or uses obscene language | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Often does not listen | | | | | | | | | | | |  | |  | | | | |  | \_\_\_\_\_ Worries about harm to others | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Often loses temper | | | | | | | | | | | |  | |  | | | | |  | \_\_\_\_\_ Worries about separation from parents | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Often engages in dangerous activities | | | | | | | | | | | | | | | | | | |  | \_\_\_\_\_ Anxious in social situations | | | |  |
| \_\_\_\_\_ Poor impulse control | | | | | | | | | | | |  | |  | | | | |  | \_\_\_\_\_ Avoidance of being alone | | | | | | | | | |  | | | | | | | |
| \_\_\_\_\_ Repetitive behaviors | | | | | | | | | | | |  | |  | | | | |  | \_\_\_\_\_ Fears losing control | | | | | | | | | |  | | | | | | | |
| \_\_\_\_\_ Seems anxious | | | | | | |  | | | | |  |  | | | | |  | | \_\_\_\_\_ Physical complaints | | | | | | | | | | | | | | | | |  | | | | |
| \_\_\_\_\_ Sleep problems | | | | | | |  | | | | |  |  | | | | |  | | \_\_\_\_\_ Worries about future events | | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Fatigued or low energy | | | | | | | | | | | |  | |  | |  | | | | \_\_\_\_\_ Worries about past behavior | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Refuses to sleep alone | | | | | | | | | | | |  | |  | |  | | | | \_\_\_\_\_ Worries about own competence | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Suicide attempt | | | | | | | | | | | |  | |  | |  | | | | \_\_\_\_\_ Marked self-consciousness | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Suicidal thoughts | | | | | | | | | | | |  | |  | |  | | | | \_\_\_\_\_ Excessive need for reassurance | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Feelings of worthlessness or guilt | | | | | | | | | | | |  | |  | |  | | | | \_\_\_\_\_ Marked inability to relax | | | | | | | | | | | | | | |  | | | | | |
| \_\_\_\_\_ Sad or hopeless | | | | | | | | | | | | | |  | |  | | | | \_\_\_\_\_ Irritable/easily frustrated | | | | | | | | |  | | | | | | |
| \_\_\_\_\_ Unable to enjoy life | | | | | | | |  | | | | | |  | |  | | | | \_\_\_\_\_ Experienced physical abuse | | | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Stolen | | | | | | | |  | | | | | |  | |  | | | | \_\_\_\_\_ Experienced sexual abuse | | | | | | | | | | | | | | |  | | | | | |
| \_\_\_\_\_ Runs away from home | | | | | |  | |  | | |  | | | | | |  | | | \_\_\_\_\_ Experienced emotional abuse | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Often lies | | | | | | | |  | | | | | |  | |  | | | | \_\_\_\_\_ Low self-regard | | | | | | | | | | | | | | |  | | | | | |
| \_\_\_\_\_ Often truant | | | | |  | | |  | | |  | | | | | |  | | | \_\_\_\_\_ Preoccupied with weight | | | | | | | | | | | | |  | | | | | |
| \_\_\_\_\_ Destroys other's property | | | | |  | | |  | | |  | | | | | |  | | | \_\_\_\_\_ Worries about body/weight or image | | | | | | | | | | | | | | | | | | |
| \_\_\_\_\_ Destroys own property | | | | | | | |  | | | | | |  | |  | | | | \_\_\_\_\_ Dieting? | | | | | | | |  | | | | | | |  | | | | | |
|  | | | | | | | |  | | | | | |  | |  | | | | \_\_\_\_\_ Self-induced vomiting | | | | | | | | | | | | | | |  | | | | | |
|  |  |  |  |  | | | | | |  | | | | | | | | | |  |  |  | | | |  | | | | | |

**How did you hear about the Rajan Center? \_\_\_\_\_** insurance company \_\_\_\_doctor \_\_\_\_\_friend

\_\_\_\_\_Rajan Center website \_\_\_\_\_\_phone book \_\_\_\_\_ school

\_\_\_\_other (please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)