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Child/Adolescent Background Information

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

Child's Name: _____ Date of First Visit _____

Completed by:_____ Relationship to Child: _____

Home Phone:_____ (**May call**: yes__no__ **May Leave Message**: yes__ no__)

Work Phone:_____ (**May call**: yes__no__ **May Leave Message**: yes__ no__)

Best Time and Place to call: _____

Child's Address: _____

Child's Gender: Male___ Female___ Date of Birth___ _____ Age _____

Child's Ethnicity: Caucasian___ Africa American___ Hispanic/Latin___ Asian___ Native American___ Bi-racial___ other (explain) _____

In case of emergency, contact: _____
Name Relationship Phone

Has your child ever seen a mental health professional (psychiatrist, psychologist, etc)? No___ Yes__

Previous Mental Health Professional/Agency_____
Name Address

Who referred you to our clinic? May we have his/her name?_____

Person responsible for financial arrangements with our clinic:_____
(Dr. Valdez is an out-of- network provider for all insurance companies.)

*** INFORMATION ON CHILD'S MOTHER ***

Mother's Name:_____

I am: ___ biological mother ___stepmother ___adopted mother other _____

Address: _____

Home Phone:_____ Work Phone: _____
(May call: Yes/no Leave Message: Yes/No) (May call: Yes/no Leave Message: Yes/No)

Date of Birth:_____ Occupation: _____

Employer_____ How Long:_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married _____ Separated _____ Divorced _____ Widowed _____

*** INFORMATION ON CHILD'S FATHER ***

Father's Name: _____

I am: __ biological father ___stepfather ___adopted father other _____

Address: _____

Home Phone: _____ Work Phone: _____
(May call: Yes/no Leave Message: Yes/No) (May call: Yes/no Leave Message: Yes/No)
Date of Birth:_____ Occupation: _____

Employer:_____ How long:_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married _____ Separated _____ Divorced _____ Widowed _____

*** GENERAL INFORMATION ***

Child's current household: Mother only ___ Father only ___ Natural parents ___ Natural Mother and Step-Father ___ Natural Father and Step-Mother ___ Blended family (both spouses with children) ___ Adoptive parents __ Grandparents___ Other Relatives __ Foster family __ Institution __ Other_____

List by Household your child's current family, beginning with the oldest member and include the child:

Primary Household (anyone who currently lives with child)
How long in this current living situation: _____

Name	Age	Gender	Relationship to you (include "step", "half", etc.)

Child lives in: House_____ Apartment ____ Duplex _____ Other_____

Second Household (non-custodial or extended family - if applicable)

Name	Age	Gender	Relationship to you (include "step", "half", etc.)

Currently involved in a custody dispute: No __ Yes __ (If yes, explain) _____

_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile		Frustrating		Friendly
__1	2	3	4	5

How often does client see non-custodial parent? _____

* CHILD'S HEALTH *

Child's Primary Care Physician: _____
Name Phone

_____
Address

Date of LAST complete physical_____

Has your child ever seen a psychiatrist? Yes___ No___
Is child currently seeing a psychiatrist? Yes___ No___ (If yes list name and address and phone):

_____
Name Address Phone

Physical Disability: Yes __ No ___ (If yes, explain) _____

Chronic Illness: Yes ___ No ___ (If yes, explain) _____

Terminal Illness: Yes ___ No ___ (If yes, explain) _____

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD Hyperactive	_____	_____	_____	_____	_____
ADHD Inattentive	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____

Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If your child has been diagnosed, who gave the diagnosis? Pediatrician____ Psychiatrist___ School____

Other _____

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

* CURRENT CONCERNS *

Indicate severity of up to 10 items that currently apply to your child. (1-mild; 2-moderate; 3-severe) Circle the item that you see as the most significant issue)

___Adjustment to life changes (changing schools, parent's divorcing, moving, etc.)
___Bed wetting daytime wetting, soiling or related problems
___Career Decisions
___Abuse (physical, emotional, sexual)
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling angry or irritable
___Feeling guilty or shameful
___Feeling sadness or depression related to grief
___Feeling sadness or depression NOT related to grief
___Gang related concerns (explain_____)
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
___Learning/Academic difficulties
___Personal Growth (no specific problem)
___Parent-Child relationship (discipline, adoption, single parent, etc.)

___Family or Step-family relationship problems
___Non-family relationship problems (teachers, peers, etc.)
___Religious or Spiritual concerns
___Sexual concerns (excessive masturbation, inappropriate acting out)
___Sexual identity concern
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Suicidal Ideation (thoughts of death, wanting to die)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Other (explain_____)
***Remember to circle the most significant issue.**

When did you first become concerned about this issue?_____

How have you attempted before now to deal with these issues? _____

_____

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

Anything else you think we need to know_____

What is the one thing I need to know to help your child today? _____

*** FAMILY HISTORY/EXPERIENCES ***

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

Raised by: Natural parents___ Single natural parent___ Grandparents___ Adoptive parent(s)___ Natural and step-parent___ Foster parents___ Institution___ Relatives___ Other_____

Stressors in the Family: Parents fighting frequently___ Parents divorced___ Financial problems___ Family member's disability or major accident or illness___ Chronic illness of family member___ Moved a lot___ Family member absent (explain)_____ Death of significant person___ Family member suicide(explain)_____
Family member emotional problems (explain) _____
other (explain) _____

History of your child having learning, emotional, behavioral problems: yes__ no__
(If yes, please explain) _____

History of family violence: yes__ no__
(If yes, please explain) _____

Has your child been abused (check all that apply): Physically___ Emotionally___ Sexually___

Has your child been neglected (check all that apply): Physically___ Emotionally___

School Problems (check all that apply): Academic problems___ Severely teased___ Discipline problems___ Unpopular___ other (explain_____)

History of anxiety symptoms include: (indicate all that apply): Obsessive worrying ___ Keyed up, on edge ___ Phobias ___ Irritable ___ Physical symptoms (below) ___ other _____

History of health/physical problems include: (check all that apply): Headache (kind) ___ Nervous stomach ___ Diarrhea ___ Bone/joint/muscle ___ PMS ___ Dizziness ___ Shortness of breath without exertion ___Heart Palpitations ___ Chest pain ___ Surgeries ___ Major illness___ Major accident___ Disability___ Chronic illness___ Hospitalization___ Developmental delay(s)___ Sleep problem___ Bedwetting___ Serious overeating or undereating___ Neurological problems/exam___ Asthma___ Other_____

History of trauma/stressor include: (check all that apply): Child separated from parent (how long and when)_____ Death of a significant person___ Death of a pet___ Incarcerated family member___ Sexual Assault___ Victim of trauma (unusual, terrifying experience)___ Medical___ Natural Disaster___ Other _____

History of interpersonal problems include: (check all that apply): Frequent arguments___ Taken advantage of___ Temper outbursts___ aggressive behavior___ Loner___ Other_____

Family Atmosphere (circle the number that best describes how you view your child's current family atmosphere)

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Family Support System (such as church, friends, relatives, school)

Hardly any support	1	2	3	4	5	Considerable support

Your child's current use of Computer, VCR, and Television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+