Melissa Korland, Ph.D.
Background Information - Child & Adolescent

Today's Date: _____ Form completed by:_____

Child's First Name: _____ Middle Initial: ___ Last Name: _____
Prefers to be called: _____

Age: _____ Birth Date: ____/___/_____ Gender: Male___ Female___
Home address: _____
_____
_____
Home phone:_____
Preferred phone number for contact: _____

Family Composition
Who is (are) the child's legal guardian(s)?
_____
Is the child adopted or in foster care? Yes / No If so, since what age? _____

Parent Name:_____ Age:_____
Occupation:_____ Employer:_____
Home phone:_____ Cell phone:_____ Business phone:_____
Address (if different from child):_____

Parent Name:_____ Age:_____
Occupation:_____ Employer:_____
Home phone:_____ Cell phone:_____ Business phone:_____
Address (if different from child):_____

Parent/Guardian Relationship:
Marital Status: ___Never married ___Married ___Separated ___Divorced ___ Widowed

Describe custody agreement, if applicable:_____
Extent of contact with noncustodial parent, if applicable: _____

Are there additional siblings**? Please circle one**:Yes or No.
If yes, please list them below (including half siblings, step siblings).

Name	Age	Gender	Live with child?
_____	_____	M / F	Yes / No
_____	_____	M / F	Yes / No
_____	_____	M / F	Yes / No
_____	_____	M / F	Yes / No
_____	_____	M / F	Yes / No
_____	_____	M / F	Yes / No

Who referred you to psychological services?_____

What concerns do you have about your child?_____
_____
_____
_____

What is the reason for your visit today? _____
_____
_____

Does your child have any developmental, behavioral or learning problems? **Please circle one**: Yes or No. If yes, please describe:_____
_____
_____
_____

School

What grade is your child in? _____

What school does your child attend? _____

Does your child have an IEP or 504 plan? Yes / No

If yes, please describe: _____

Gifted/Honors placement? Yes / No

If yes, please describe: _____

In general, what is your child's attitude towards school?

Please circle one: Very negative, Negative, Neutral, Positive, or Very positive.

Overall, please indicate the level of your child's grades/academic performance.

Please circle one: Nearly failing, Below average, Average, Above average, or Superior.

What other activities or commitments does your child have after school and/or on weekends?_____
_____

Mental Health History

Please list any previous mental health service your child has received:

Provider/Agency	Dates	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any psychiatric/psychotropic medication your child is taking now and any ever prescribed in the past:

Medication	Dosage	Dates	Reason	Prescribed By
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medical History

Does your child have any medical problems? **Please circle one**: Yes or No. If yes, please describe: _____
_____
_____

Please list any medications that your child is currently taking: _____
_____
_____

Does your child have vision or hearing impairments? Yes / No If yes, please describe: _____
_____

Has your child ever been treated by a speech therapist, occupational therapist or physical therapist? Yes / No If yes, please describe:
_____
_____

Additional Commets: _____
_____
_____