

**Midwest Behavioral Care, Ltd.**

Administrative Office

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**CHILD/ADOLESCENT BACKGROUND FORM**

Child's name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Parent/Guardian work #: \_\_\_\_\_

List child's relatives including those by previous and subsequent marriages and any deceased siblings (with date of death).

Name	Age	Relationship	Grade or Occupation	Living in Household

If not presently with the child, please give name and whereabouts of biological parent(s):

Legal Custodian of child, if other than natural parent(s): \_\_\_\_\_  
 If child adopted? \_\_\_\_\_ If yes, what age was child when adopted? \_\_\_\_\_

Parents' Marital Status: (Check as many as apply)

Married to each other       Separated  
 Divorced                       Widowed  
 Mother remarried               Father remarried  
 Never married to each other; living:  Separately;  Together

If the child's parents are divorced, who has legal custody? \_\_\_\_\_  
 What are the visitation arrangements? \_\_\_\_\_

Are there any problems with this? \_\_\_\_\_ What kind? \_\_\_\_\_  
 How do the parents feel about this child? \_\_\_\_\_

Name of person filling out this form: \_\_\_\_\_  
 Who referred you to us? \_\_\_\_\_  
 Address of referral source: \_\_\_\_\_  
 May we contact referral to thank them?  YES       NO

## CHILD'S CURRENT PROBLEMS AND THEIR HISTORY

Describe the child's current problem(s) (medical, behavioral, emotional):

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Please check any of the following which are problems with this child:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Depressed  | <input type="checkbox"/> Hyperactivity                     | <input type="checkbox"/> Stealing              |
| <input type="checkbox"/> Anxious  | <input type="checkbox"/> Poor attention                    | <input type="checkbox"/> Cruelty               |
| <input type="checkbox"/> Nervous habits   | <input type="checkbox"/> Poor concentration                | <input type="checkbox"/> Fire setting          |
| <input type="checkbox"/> Easily upset   | <input type="checkbox"/> Memory problems                   | <input type="checkbox"/> Running away          |
| <input type="checkbox"/> Panic Attacks  | <input type="checkbox"/> Clumsiness                        | <input type="checkbox"/> Temper tantrums       |
| <input type="checkbox"/> Guilt feelings   | <input type="checkbox"/> School problems                   | <input type="checkbox"/> Destructiveness       |
| <input type="checkbox"/> Tiredness & fatigue  | <input type="checkbox"/> Difficulty following instructions | <input type="checkbox"/> Physical aggression   |
| <input type="checkbox"/> Sleep problems   | <input type="checkbox"/> Day-dreaming too much             | <input type="checkbox"/> Drug or alcohol abuse |
| <input type="checkbox"/> Shyness  | <input type="checkbox"/> Speech problems                   | <input type="checkbox"/> Sexually active       |
| <input type="checkbox"/> Nail biting  | <input type="checkbox"/> Toilet problems                   | <input type="checkbox"/> Vandalism             |
| <input type="checkbox"/> Self-destructive   | <input type="checkbox"/> Jealousy                          | <input type="checkbox"/> Verbal aggression     |
| <input type="checkbox"/> Extreme fears  | <input type="checkbox"/> Disorientation                    | <input type="checkbox"/> Resentment            |
| <input type="checkbox"/> Self-critical  | <input type="checkbox"/> Elevated mood                     | <input type="checkbox"/> Overly sensitive      |
| <input type="checkbox"/> Obsessions & compulsion  | <input type="checkbox"/> Oppositional                      | <input type="checkbox"/> Trauma History        |
| <input type="checkbox"/> Eating problems  | <input type="checkbox"/> Impulsive                         | <input type="checkbox"/> Physical              |
| <input type="checkbox"/> Irritable  | <input type="checkbox"/> Medical Illness                   | <input type="checkbox"/> Sexual                |
| <input type="checkbox"/> Feelings of worthlessness  |  | <input type="checkbox"/> Emotional             |
| <input type="checkbox"/> Delusions (believing things which are not true)                  |  | <input type="checkbox"/> Perpetrator           |
| <input type="checkbox"/> Hallucinations (hearing voices/seeing things that are not there) |  |  |

**Risk Assessment:** (underline all that apply)

<b>Suicidality</b>	Not Present	Ideation	Plan	Means	Prior Attempt
<b>Homicidality</b>	Not Present	Ideation	Plan	Means	Prior Attempt

Current Impairment: Categories	Impairment Level (circle level)				
	No Impairment	Mild Impairment	Moderate Impairment	Marked Impairment	Extreme Impairment
Relationship/Family	1	2	3	4	5
Job/School/Performance	1	2	3	4	5
Friendship/Peer Relationships	1	2	3	4	5
Hobbies/Interests/Play Activities	1	2	3	4	5
Physical Health	1	2	3	4	5
Legal Status (Arrest, Probation)	1	2	3	4	5
Activities of Daily Living (personal hygiene, bathing, etc.)	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleeping Habits	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control His/Her Temper	1	2	3	4	5

When did the current problems start or when were they first noticed? \_\_\_\_\_

Is the child aware of the problem(s)? \_\_\_\_\_ If yes, how is this awareness expressed: \_\_\_\_\_

Has the possibility of evaluation been discussed with the child? \_\_\_\_\_

If yes, what was the child's reaction? \_\_\_\_\_

List all professionals and agencies which have been involved in the current problem(s), dates of contact, and whether it was beneficial:

\_\_\_\_\_ Date: \_\_\_\_\_ Beneficial? \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ Beneficial? \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ Beneficial? \_\_\_\_\_

Has the child had medical, behavioral, or emotional problems other than the current one(s)?

\_\_\_\_\_ No \_\_\_\_\_ Yes. If yes, please specify and list agencies involved and dates of contact.

\_\_\_\_\_ Date: \_\_\_\_\_ Beneficial? \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ Beneficial? \_\_\_\_\_

Who disciplines the children, and how? (Be specific) \_\_\_\_\_

How does your child respond to discipline? \_\_\_\_\_

What are the child's strong points or favorable characteristics? \_\_\_\_\_

What games or particular interest does this child enjoy? \_\_\_\_\_

What kinds of things might serve as rewards for this child? \_\_\_\_\_

What religion does this child's family endorse? \_\_\_\_\_

How involved is the child with a religious system? \_\_\_\_\_

\_\_\_\_\_ Are the child's religious beliefs important to him/her? \_\_\_\_\_

### Substance Use and Dependency

How often does your child currently use the following substances? (Place a check in the column to indicate current use; if your child past use was different, indicate this by writing "past" in the appropriate column next to each substance.)

	Daily	3-5x/week	1-2x/week	2-3/month	1/month	seldom	never
Beer	___	___	___	___	___	___	___
Wine	___	___	___	___	___	___	___
Distilled Alc.	___	___	___	___	___	___	___
Marijuana	___	___	___	___	___	___	___
Cocaine	___	___	___	___	___	___	___
Crack	___	___	___	___	___	___	___
Barbiturates	___	___	___	___	___	___	___
Amphetamines	___	___	___	___	___	___	___
Tranquilizers	___	___	___	___	___	___	___
Analgesics	___	___	___	___	___	___	___
Heroin	___	___	___	___	___	___	___
Tobacco	___	___	___	___	___	___	___
Caffeine	___	___	___	___	___	___	___
Other (List)	___	___	___	___	___	___	___
Other (List)	___	___	___	___	___	___	___

Has your child had problems as a result of his/her substance use? \_\_\_\_\_ Describe \_\_\_\_\_

Has anyone in your child's family ever had problems with substance abuse or dependency? \_\_\_\_\_  
Who, and what substances? \_\_\_\_\_

Has anyone in your family been involved in treatment for substance use or dependency? \_\_\_\_\_  
Who, and what treatment? \_\_\_\_\_

Has anyone in your family been involved with a 12-step group (AA, Al-Anon, etc.)? \_\_\_\_\_  
Are they now? \_\_\_\_\_ What group(s)? \_\_\_\_\_

### TREATMENT GOALS

List the benefits you hope your child to derive from counseling/therapy. This is most important. Please be specific.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

Do you think this child would be helped more by:

- |   |  |
|---|--|
| <input type="checkbox"/> Counseling with parents                                | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Counseling with the child individually                 | <input type="checkbox"/> Group therapy         |
| <input type="checkbox"/> Family Counseling including parents and child          | <input type="checkbox"/> Medication            |
| <input type="checkbox"/> Systematic Skills to change specific problem behaviors |  |
| <input type="checkbox"/> Other: _____   |  |

### CHILD'S EDUCATION

School your child is presently attending? \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Grade: \_\_\_\_\_ Principal: \_\_\_\_\_

Teachers: \_\_\_\_\_

How does your child do in school, in terms of grades, ability, and behavior? \_\_\_\_\_

Has your child repeated any grades? \_\_\_\_\_ If yes, provide what grade and the reason for repeating the grade: \_\_\_\_\_

Has your child required special help in any of the schools attended? \_\_\_\_\_

Dates \_\_\_\_\_ School \_\_\_\_\_ Nature of help \_\_\_\_\_ Beneficial? \_\_\_\_\_

Dates \_\_\_\_\_ School \_\_\_\_\_ Nature of help \_\_\_\_\_ Beneficial? \_\_\_\_\_

Child's behavior problems in school: \_\_\_\_\_

What psychological or achievement test has this child had previously? \_\_\_\_\_

What were the results or scores? \_\_\_\_\_

### CHILD'S DEVELOPMENT

Please list any problems encountered during the pregnancy and/or delivery and the first weeks of life: \_\_\_\_\_

Was the child administered oxygen at birth? \_\_\_\_\_

### EARLY DEVELOPMENT

Was your child an easy-to-care-for infant? \_\_\_\_\_ If not, please explain: \_\_\_\_\_

Was your child an easy-to-care-for toddler? \_\_\_\_\_ If not, please explain \_\_\_\_\_

Please list any problems encountered in the first three years of life: \_\_\_\_\_

If your child has started puberty, has the onset appeared to cause any difficulties? \_\_\_\_\_ If yes, please give details \_\_\_\_\_

Has your child ever behaved or talked in a way that was not sexually appropriate for a boy/girl or his/her age? \_\_\_\_\_ If yes, give details: \_\_\_\_\_

**CHILD'S HEALTH**

Name of family physician \_\_\_\_\_

Address: \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_ If yes, please give details: \_\_\_\_\_

Has your child ever had a fever above 105 degrees? \_\_\_\_\_ If yes, please give child's age at the time and the cause: \_\_\_\_\_

Has the child had any significant accidents or injuries (including broken bones)? \_\_\_\_\_

If yes, give details \_\_\_\_\_

Has your child ever lost consciousness? \_\_\_\_\_ If yes, give details: \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_ If yes, give details \_\_\_\_\_

Has your child had any operations? \_\_\_\_\_ If yes, give details \_\_\_\_\_

Has your child ever had seizures (convulsions) \_\_\_\_\_ If yes, give details \_\_\_\_\_

Has your child received medications in the past for emotional, physical, learning, or behavioral problems? \_\_\_\_\_ If yes, please give the following details:

Problem: \_\_\_\_\_

Age when first prescribed: \_\_\_\_\_

Medication: \_\_\_\_\_ Daily Dose: \_\_\_\_\_

Times per day: \_\_\_\_\_ Taken since: (date) \_\_\_\_\_

Who prescribed the medication(s)? \_\_\_\_\_

Is it helping? \_\_\_\_\_ Side effects? \_\_\_\_\_

Is the child presently taking any other medications? \_\_\_\_\_ If yes, problem: \_\_\_\_\_

Age when first prescribed? \_\_\_\_\_

Medication: \_\_\_\_\_ Daily Dose: \_\_\_\_\_

Times per day: \_\_\_\_\_ Taken since (date) \_\_\_\_\_

Who prescribed the medication(s)? \_\_\_\_\_

Is it helping? \_\_\_\_\_ Side Effects? \_\_\_\_\_

Please describe any occurrences of birth defects, mental retardation, nerve disease (cerebral palsy, epilepsy) and psychiatric condition in the immediate family and the child's blood relatives:

\_\_\_\_\_

### SIGNIFICANT EVENTS

Have any of the following events occurred in your family? If so, please describe:

Event	Year	Describe
_____ move to a new place	_____	_____
_____ significant separation from a parent	_____	_____
_____ loss of someone very close	_____	_____
_____ frightening experiences	_____	_____
_____ change of school	_____	_____
_____ serious illness or injury in family	_____	_____
_____ death in family	_____	_____
_____ change in family's financial status	_____	_____
_____ separation or divorce	_____	_____
_____ brother or sister leaving home	_____	_____
_____ marriage of sibling	_____	_____
_____ emotional difficulties	_____	_____
_____ legal problems	_____	_____
_____ other (specify)	_____	_____

### MARITAL HISTORY OF PARENTS

How would you describe your marital relationship? \_\_\_\_\_

Have you sought outside help with regards to marital problems? \_\_\_\_\_  
If yes, please give details \_\_\_\_\_

Have any extended family members had problems with substance abuse (drugs, alcohol)? \_\_\_\_\_  
If yes, please give details \_\_\_\_\_

Have any extended family members been involved in incest (sexual interaction between a parent and child or between the children)? \_\_\_\_\_ If yes, please give details: \_\_\_\_\_

Has any family member been sexually, physically, or emotionally abused? \_\_\_\_\_ If yes, please give details: \_\_\_\_\_

Please describe any problems that occurred while the child's father was growing up: \_\_\_\_\_

Please describe any problems that occurred while the child's adoptive, step, or foster parent(s) or guardians were growing up: \_\_\_\_\_

