Midwest Behavioral Care, Ltd.
Administrative Office

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CHILD/ADOLESCENT BACKGROUND FORM
(Parent or guardian must complete by first session)

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):

____
____
____
____
____
____
____
____
____

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

___ Depressed
___ Anxious
___ Nervous habits
___ Easily upset
___ Panic Attacks
___ Guilt feelings
___ Tiredness & fatigue
___ Sleep problems
___ Shyness
___ Nail biting
___ Self-destructive
___ Extreme fears
___ Self-critical
___ Obsessions & compulsion
___ Eating problems
___ Irritable
___ Feelings of worthlessness
___ Delusions (believing things which are not true)
___ Hallucinations (hearing voices/seeing things that are not there)

___ Hyperactivity
___ Poor attention
___ Poor concentration
___ Memory problems
___ Clumsiness
___ School problems
___ Difficulty following instructions
___ Day-dreaming too much
___ Speech problems
___ Toilet problems
___ Jealousy
___ Disorientation
___ Elevated mood
___ Oppositional
___ Impulsive
___ Medical Illness

___ Stealing
___ Cruelty
___ Fire setting
___ Running away
___ Temper tantrums
___ Destructiveness
___ Physical aggression
___ Drug or alcohol abuse
___ Sexually active
___ Vandalism
___ Verbal aggression
___ Resentment
___ Overly sensitive
___ Trauma History
  ___ Physical
  ___ Sexual
  ___ Emotional
  ___ Perpetrator

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

Suicidality	Not Present	Ideation	Plan	Means	Prior Attempt
Homicidality	Not Present	Ideation	Plan	Means	Prior Attempt

Current Impairment:

Impairment Level (circle level)

Categories	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:

___ Counseling with parents
___ Counseling with the child individually
___ Family Counseling including parents and child
___ Systematic Skills to change specific problem behaviors
___ Other: ____
___ Psychological Testing
___ Group therapy
___ Medication

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:____
____