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Child Biographical Information and Symptom Description

Please fill this form out as completely as possible. It will help me in our work together. If you feel uncomfortable answering a question that's ok. Just write "Do not care to answer" in the space provided.

Date: _____

Child's Name: _____
Last First Middle

Address: _____
Street City State Zip

Date of Birth: _____ Age: _____ Gender: _____

School & Grade: _____

Emergency Contact other than primary parent/guardian(s):

Name:_____ Phone :_____

Who referred you?:_____

Who has legal rights to make medical & educational decisions for your child?
Please provide any relevant court documentation regarding physical/legal custody if relevant.

Briefly describe the reason for referral (*I will ask for more details about this later).*

Cultural background information. *Please describe relevant cultural information including ethnic background, religious affiliation, family values, important customs/traditions, languages spoken in the home, and community groups/participation.*

PARENT/GUARDIAN INFORMATION

Please provide biographical information on each important parent/guardian in your child's life. Include biological, step, foster, and adoptive parents. If there aren't enough spaces, write the others on the back of this page.

Adult 1 Name: _____Relationship:_____

Phone Number:_____ Email: _____

Is it ok to leave confidential/private messages at the phone number provided? Yes / No

Adult 2 Name: _____Relationship:_____

Phone Number: _____ Email: _____

Is it ok to leave confidential/private messages at the phone number provided? Yes / No

MEDICAL HISTORY OF THE CHILD

Pediatrician: *Name and phone number*

Other Medical doctors / specialists: *Names and phone numbers*

Date of last physical exam:_____

Please tell me about any major medical conditions, surgeries, accidents, or illnesses.

List ***all*** medications your child is currently taking. Include dosages and reason for taking.

Family Medical History: *Please list any medical illnesses that run in the family.*

Please indicate if your child has experienced any of the following:

Symptom	Yes / No	If 'yes', what age?
Severe headaches		
Head injury		
Fainting spells		
Seizures or convulsions		
Vision problems		
Hearing impairment		
Difficulty with speaking		
Heart disease		
Difficulty with sleeping		
Abrupt weight gain/loss		
Asthma		
Frequent diarrhea/constipation		
Frequent nausea/vomiting		
Bedwetting		
Soiling self		
Allergies (medication, food, pollen, etc)		

CURRENT SYMPTOMS / CONCERNS

What is the major reason for seeking services at this time?

Please place a check next to current concerns / symptoms.

___Headache ___Stomach aches ___Nightmares ___ Weight Change

___ Bowel trouble ___ Grief/Loss ___ Binge eating ___ Muscle aches

___ Withdrawn ___ Anxiety/Worry ___ Fears ___ Sad / Hopeless

___Trauma ___Low self-esteem ___ Foster/Adopted ___ Refusal to share

___Sleep problems ___Frequent tantrums ___Panicky ___Always tired

___Hyperactive ___Experienced trauma ___Social concerns ___Divorce/Separation

___School issues ___Developmental delays ___Aggression ___Disobedient

___ Risk taking ___ Self-harm ___ Suicidal thoughts or actions

___Sexualized play ___Denies affection from parents ___Separation Anxiety

___Acts older/younger than age ___Adjustment difficulty ___ Communication difficulty

How long have you observed these symptoms?

Please answer the following questions for <u>each</u> parent-child dyad.

Would you consider your relationship mutually enjoyable?

What has given you the most satisfaction / joy in your role as a parent?

Describe the level of distress in your relationship with your child?

What has been the most difficult part of parenting your child?