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Date:_____

Basic Information

Client's Name:_____ D.O.B:_____ Age_____

Parent(s) Providing information: _____

Referral Source:_____ Legal Status: Vol.____ Invol.___

Presenting Problem and Symptoms:

_____

_____

_____

_____

_____

_____

_____

_____

To what extent have these problems disrupted your child's school life in the last month?

Not at all Mildly Moderately Mostly Extremely

0----------1----------2----------3----------4----------5----------6--------7----------8----------9----------10

To what extent have these problems disrupted your child's life with family and friends in the last month?

Not at all Mildly Moderately Mostly Extremely

0----------1----------2----------3----------4----------5----------6--------7----------8----------9----------10

To what extent have these problems disrupted your family's life in the last month?

Not at all Mildly Moderately Mostly Extremely

0----------1----------2----------3----------4----------5----------6--------7----------8----------9----------10

Which of these relate to your child?

___withdrawn
___increased aggression
___crying spells
___anger outbursts
___physical abuse issues
___change in friends
___hyperactive
___thoughts of hurting self
___other: _____
___depressed
___irritable
___bedwetting
___oppositional
___sexual abuse issues
___obsessions
___decreased energy/motivation
___thoughts of hurting others
___feelings of hopelessness
___school difficulties
___nightmares
___non-compliant
___interested in firesetting
___perfectionistic tendencies

Mental Health Treatment History

Agency/Hospital Dates Treatment Received and Outcome

_____

_____

Developmental History:

1. How was the mother's health during pregnancy and birth?

_____

2. Were there any complications during birth?

_____

_____

3. What the child born prematurely? If so, how early? _____

4. Have you or any other adults had any concerns about your child's development in any of the following areas?

	Y	N
Speech and language Development	____	____
Hearing	____	____
Vision	____	____
Intelligence/ability to learn	____	____
Bladder/bowel control	____	____
Emotional/maturity	____	____
Social skills	____	____
Eating Habits	____	____
Fine motor skills (write, color, etc.)	____	____
Gross motor skills (walk, run, etc.)	____	____

Medical History

1. Primary Care Clinic: _____ Doctor: _____

2. Past hospitalizations, surgeries, medical issues

_____

_____

2. Medication

_____

_____

3. Current Psychiatrist

_____

4. Family history of medical problems (mental health, suicide, learning disabilities, substance abuse, etc.)

_____

_____

_____