CHILD BACKGROUND FORM

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Child's Name_____ Date_____

Date of Birth _____Age_____SSN#_____

Address _____

_____

Primary

Insurance Company _____ Policy # _____

_____Group # _____

Insurance Company Address: _____

_____

Relationship to Insured Member ____Self ____Spouse _____Child/Dependent ____Other

Member's Date of Birth _____

Mental Health Benefits:

Deductible (if applicable) _____ Co-pay _____

Number of allowed sessions per year _____

Secondary

Insurance Company _____ Policy # _____

_____Group # _____

Insurance Company Address: _____

_____

Member's Date of Birth _____

Relationship to Insured Member ____Self ____Spouse _____Child/Dependent ____Other

Mental Health Benefits:

Deductible (if applicable) _____ Co-pay _____

Number of allowed sessions per year _____

Primary Care Physician _____

Address _____

_____

Phone # _____

Emergency Contact Person _____ Relationship _____

Phone # _____

You can receive reminders of appointment dates and time by email or text message. Please provide the email address or mobile phone number you would like Dr. Davies to use for this service _____

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*The purpose of this questionnaire is to obtain comprehensive information about your child's background. This will greatly facilitate your treatment. Please be assured that all the information you share here will be held as <u>confidential</u>.

Who referred you for services?	Physician _____
	Friend/Family_____
	Insurance Company _____
	Other _____
	Self
Which services are you seeking?	Individual Therapy
(circle all that apply)	Family Therapy
	Psychological Testing/Assessment

Have your child ever received mental health services before? Yes No

If yes, please list the provider's name and dates of service _____

_____

_____

_____

_____

Identifying Information

Name your child goes by: _____

Gender: _____ Male _____ Female

Phone numbers where family can be reached _____

(specify home, cell or work #) _____

_____

_____

Family Information

*Mother's Name*_____ Birthdate_____

Mother's occupation _____ Typical work hours_____

Mother's best phone number _____

*Father's Name*_____ Birthdate _____

Father's occupation _____ Typical work hours_____

Father's best phone number _____

Who has legal custody of the child? _____

Is your child adopted? ___ Yes ___ No If yes, for how long and by whom? _____

_____

Are parents married? ___ Yes ___ No If yes, when? _____

Are parents separated? ___ Yes ___ No If yes, when? _____

Are parents divorced? ___ Yes ___ No If yes, when? _____

Is/are there step-parent(s)?___ Yes ___ No

(If there are other adults, such as previous step-parents, who have been involved in the child's life, you may include their names below.)

Step-Parent(s)' or Legal Guardian(s)' Name(s): _____

_____

_____

_____

Siblings (List all full, half, or step brothers and sisters of patient, living or dead, in order of birth. Add your own page, if needed.)

	Name	Age	Sex	Relationship To Child	Living with Child (Y/N)
1.					
2.					
3.					
4.					
5.					
6.					

Please provide name and relationship to the child of anyone else living in the home currently.

_____
_____
_____

Family History of Medical and/or Emotional Difficulties

Describe any mental health or medical problems in family members:

_____
_____
_____
_____

History of the Current Problem

In your own words, what difficulties or problems are bringing your child here at this time?

_____
_____
_____
_____
_____
_____
_____

At what age was the child's problem first noted? _____

Has your child had psychological treatment for any other problem? ____ Yes ____ No

If yes, where? _____ When? _____

Does anyone else in the family have a similar problem? _____

_____

Birth, Developmental and Medical History of the Child

Did mother use any of the following during pregnancy?

Tobacco _____ Yes _____ No

Alcohol _____ Yes _____ No

Drugs _____ Yes _____ No

Describe any difficulties during pregnancy: _____

_____

_____

_____

Length of pregnancy _____ Birthweight _____

Describe any difficulties during delivery: _____

_____

Were there any medical problems noted at or immediately following birth? _____

_____

_____

Developmental History of Child

Please state the age at which your child did the following. If you do not remember the exact age, give the approximate age.

MOTOR & LANGUAGE SKILLS

Sat alone _____ Started using single words (other than

Stood alone _____ "mama" and "dada")_____

Walked alone _____ Used 3-word sentences _____

Please indicate any difficulties your child has had with the following:

Toileting ____ In the past ____ Currently ____ Never

Eating ____ In the past ____ Currently ____ Never

Sleeping ____ In the past ____ Currently ____ Never

Medical History of Child

(If you need more room, feel free to add your own page)

Describe any serious accident, illness or injury which your child has had and at what age:

_____

_____

_____

_____

_____

_____

Please list any operations your child has had and when_____

_____

_____

_____

Is your child taking any prescription medications? Yes No

Please list current medications being taken, with any psychotropic medications (antidepressants, anti-anxieties, etc.) listed first:

MEDICATION	DOSE	DATE BEGAN	PRESCRIBING PHYSICIAN
		/ /	/
		/ /	/
		/ /	/
		/ /	/
		/ /	/
		/ /	/
		/ /	/
		/ /	/
		/ /	/
		/ /	/

Child's current height _____ weight _____

Educational History

Attended pre-school? _____ Yes _____ No

Attended kindergarten? _____ Yes _____ No

In special classes? _____ Yes _____ No

Type of classes? _____ When? _____

Repeated grade(s)? _____ Yes _____ No

Ever had psychological testing at school? _____ Yes _____ No

(If so, please attach a copy of the report or have a copy sent to us.)

Ever been suspended/expelled? _____ Yes _____ No

If yes, what grade(s)? _____ Why? _____

_____

School now attending: _____ Grade _____

School address: _____

School district: _____

Name of classroom teacher: _____

Telephone number of school: _____

Strengths and Assets of the Child and Family

What are your child's strengths?

_____
_____
_____
_____

What are your family's strengths?

_____
_____
_____
_____

Please tell me anything else you think will be of help in my understanding your child. Include any questions that you would like me to answer. Feel free to add your own page if you need more room.

_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire!

Signature of person filling out form:

_____

Relationship to the child: _____ Date _____