# CHILD AND ADOLESCENT BACKGROUND INFORMATION

*Welcome to New Leaf Clinic. Please answer all information as completely as possible. If applicable, both mother and father should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Please ask for assistance, if needed. Your child's assessment counselor will discuss your responses with you during the Parent Interview.*

*Child's Name:*_______________________________________________ *Today's Date* ________________
Last First MI

*Completed by:* _________________________ *Relationship to Child:* _________________________

*Home Phone*: ________________________ (Okay to call? Yes No Okay to Leave Message? Yes No)
*Work Phone:* _________________________ (Okay to call? Yes No Okay to Leave Message? Yes No)
*Cell Phone:* __________________________ (Okay to call? Yes No Okay to Leave Message? Yes No)
*Child's Address*: _____________________________________________________________________
Street City State Zip

*Child's Gender*: Male__ Female__ *Date of Birth*___/___/___ *Age*____ *SS#*______________________

*Child's Ethnicity:*
Africa American___ Bi-racial___ Hispanic/Latin___
Asian___ Caucasian___ Native American___ Other ________________

*Child's Legal Guardian* (Managing Conservator)*:* ___________________________________________
**(If the child is not living with both biological parents, both adoptive parents, or only living parent, the clinic requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page). (The photocopy should be stapled to this form.)**

*Emergency contact:* _____________________________________________________________________
Last First Relationship Phone

*Child's School:* __________________________________________________________________________

*Current School Address & Phone* ____________________________________________________________

*Grade Level (*now): _______ *Has your child ever been retained? Yes No If yes, which grade* _______

*Current Teacher(s): 1)*____________________ *2)*_____________________ *3)*______________________

*Current School Counselor:* _________________________________________________________________

*Is your child receiving special education or other services? Yes No*
*(explain)*________________________________________________________________________________

*Has your child ever seen a mental health professional (psychiatrist, psychologist, or counselor)*? Yes No
(If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency__________________________________________________
Name Address

Phone________________ Dates of Service_______________________________(beginning - ending)

*Has your child been hospitalized for mental health concerns?* Yes No
If yes: When ____________________ Where_____________________________________________________

*How did you hear about New Leaf Clinic?* (Check those that apply):

__Mental Health Professional __School personnel __Website __Physician __Friend __Other

*** INFORMATION ON CHILD'S MOTHER ***

*Mother's Name:* _________________________________________________________________
*Last* *First* *MI*

*I am:* *__ biological mother* *___stepmother* *___adopted mother* *Other*________________

*Marital Status:* *__Married* *__Divorced* *__Separated* *__Single*

*Address:* ________________________________________________________________________________
*Street* *City* *State* *Zip*

*Home Phone:* _________________________________ *Work Phone:* _________________________
(May call: Yes No Leave Message: Yes No ) (May call: Yes No Leave Message: Yes No )

*Date of Birth:* ________________________________ *Occupation:* _________________________
*Employer* __________________________________ *How Long:* __________________________

*History of learning, emotional, or behavioral problems:* Yes No
(If yes, please explain) _____________________________________________________________________

*History of alcohol/drug/substance abuse:* Yes No
(If yes, please explain) _____________________________________________________________________

*** INFORMATION ON CHILD'S FATHER ***

*Father's Name:* _________________________________________________________________________
*Last* *First* *M.*

*I am* *__ biological father* *___stepfather* *___adopted father* *Other* ___________________

*Marital Status:* *__Married* *__Divorced* *__Separated* *__Single*

*Address:* ________________________________________________________________________________
*Street* *City* *State* *Zip*

*Home Phone:* _________________________________ *Work Phone:* _________________________
(May call: Yes No Leave Message: Yes No ) (May call: Yes No Leave Message: Yes No)

*Date of Birth:* ________________________________ *Occupation:* _________________________
*Employer:* __________________________________ *How long:* __________________________

*History of learning, emotional, or behavioral problems:* Yes No
(If yes, please explain) _____________________________________________________________________

*History of alcohol/drug/substance abuse:* Yes No
(If yes, please explain) _____________________________________________________________________

## * GENERAL INFORMATION *

*List by household (if your child resides in multiple homes) your child's current family, beginning with the oldest member and **include the child**:*

Primary Household (where your child spends the majority of his or her time)
How long in this current living situation: ____________________________________________________

| Name | Age | Gender | Relationship to client (include step, half, etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Secondary Household (non-custodial or extended family - if applicable)

| Name | Age | Gender | Relationship to client (include step, half, etc.) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently involved in a custody dispute: No Yes (If yes, explain)
______________________________________________________________________________________
______________________________________________________________________________________

*If divorced from your child's other parent, circle the number which best describes your relationship with your ex-spouse.*

Hostile Frustrating at Times Friendly
1______________2________________3______________4_____________5

*How often does your child see non-custodial parent?* ______________________________

## * CHILD'S HEALTH *

*Child's Primary Care Physician:* ____________________________________________________________
Name Phone

______________________________________________________________________________________
Address City State Zip Code

*Date of LAST complete physical or "well-check"*__________________

*Physical Disability:* Yes No (If yes, explain) _______________________________________________

*Chronic Illness:* Yes No (If yes, explain) _______________________________________________

*If your child has ever received a mental health-related diagnosis, or has taken medication for a mental health-related condition, please fill out the following (if extra space is needed, attach a separate sheet):*

Diagnosis　　Date of Diagnosis　　Name of medication　　Dosage

____________________　　______________　　________________　　_______________

Diagnosis　　Date of Diagnosis　　Name of medication　　Dosage

____________________　　______________　　________________　　_______________

(If you do not know the name and dosage of current medication, please bring the medication to the parent interview)

*If your child has been diagnosed, who gave the diagnosis?*
Counselor/Psychologist___ Family Physician___ Psychiatrist___ School___ Other________

Name: ________________________________________ Phone #: _____________________________

*What other medication is your child currently taking?*
Medication　　Dosage　　Reason?

________________________________　　________________　　___________________________

________________________________　　________________　　___________________________

________________________________　　________________　　___________________________

*** CURRENT CONCERNS ***

*Please list all of the concerns you currently have about your child. Please be specific. Indicate which concern is your primary reason for seeking assessment services:*

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

*When did you first become concerned about the primary issue?* __________________________________

*How have you attempted to deal with this issue in the past?* _____________________________________

______________________________________________________________________________________

## * CHILD'S BEHAVIORAL AND EMOTIONAL HISTORY *

For each of the following items that apply, write in your child's approximate age at the time it occurred.

*School Concerns:*
__Academic problems __Discipline Problems __Severely teased __Unpopular
__Anxiety issues __Speech/Language Problems (explain)________________________________________
__Other (explain) ____________________________________________________________________________

*History of Emotional Concerns:*
__Refusal to speak in certain situations __Appetite Changes __Extreme Sadness
__Tics or Nervous Habits __Obsessive Thoughts __Suicidal Thoughts __Hearing Voices
__Phobias __Extreme Anxiety __Other (explain) ____________________________________________

*History of Behavior Concerns:*
__Aggressive Behavior (explain)___________________________________________________________
__Alcohol/Drug Use __Attention problems __Overly Active __Frequent arguments
__Impulsive __Loner __Lack of Respect for Authority Figures __Aggression toward animals
__Victim of Bullying __Perpetrator of Bullying __Fighting
__Tantrums (explain)______________________________________________________________________
__Issues Related to Toilet Training (explain)_____________________________________________________
__Other (explain) ____________________________________________________________________________

*History of Health/Physical Problems:*
__Asthma __Stomachaches __Bedwetting __Neurological problems __Headaches(type)____
__Serious overeating/undereating __Chronic Illness __Major Illness
__Hospitalizations (explain)_______________________________________________________________
__Developmental delay(s)__________________________________________________________________
__Major Accident(s)_______________________________________________________________________
__Sleep problem(s)________________________________________________________________________

*History of Unique Events/Traumas:*
__Child separated from parent (how long and when)______________________________________
__Death of a pet __Death of a significant person __Incarcerated family member __Medical
__Natural Disaster __Sexual Assault __Physical Abuse __ Victim of trauma
__Other______________________________________________________________________________

## * FAMILY ATMOSPHERE *

Circle the number that best describes how you view your child's current family atmosphere:

| | | | | | | |
|---|---|---|---|---|---|---|
| Very lenient | 1 | 2 | 3 | 4 | 5 | Very strict |
| Very non-religious | 1 | 2 | 3 | 4 | 5 | Very religious |
| Chaotic | 1 | 2 | 3 | 4 | 5 | Highly structured |
| Few expectations | 1 | 2 | 3 | 4 | 5 | High expectations |
| Inconsistent | 1 | 2 | 3 | 4 | 5 | Consistent |

*Family Support System (such as friends, relatives, church, school):*

Hardly any support 1 2 3 4 5 Considerable support

*Your child's current time spent with the Computer, Television/DVD, and Video Games:*

Computer (circle approximate **hours spent each week**)

2-5 6-10 11-15 16-20 21+

TV/DVD (circle approximate **hours spent each week**)

2-5 6-10 11-15 16-20 21+

Video Games (circle approximate **hours spent each week**)

2-5 6-10 11-15 16-20 21+

*What do you enjoy most about your child?* ____________________________________________________

*What do you find most difficult about your child?* _______________________________________________

*Anything else you think we need to know*_____________________________________________________

*What is the one thing I need to know to help your child today?* ___________________________________