CHILD AND ADOLESCENT BACKGROUND INFORMATION

Welcome to New Leaf Clinic. Please answer all questions as completely as possible. Information given is strictly confidential and beneficial in providing you and your child with the best possible service.

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)

Mother's email: _____ Father's email: _____

Address: _____
Street City/State Zip

Alternate Address (if applicable): _____
Street City/State Zip

Child's Full Name:_____ Today's Date: _____

Child's Gender: Male ___ Female ___ Date of Birth _____/_____/_____ Age _____

Child's Ethnicity:

___ African American	___ Bi-racial	___ Hispanic/Latin
___ Asian	___ Caucasian	___ Native American
___ Other		

Emergency contact (someone other than your child's parents):

_____	_____	_____
Name	Relationship	Phone number

Child's School: _____

School Address: _____

Grade Level: _____ 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

If yes, explain: _____

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

Previous Mental Health Professional/Agency: _____

Address: _____

Phone number: _____ Dates of Service: _____

Has your child been hospitalized for mental health concerns? Yes No

If yes, when? _____ Where? _____

How did you hear about New Leaf Clinic?

____ Health Professional ____ School ____ Website ____ Friend ____ Other

CURRENT CONCERNS

Please list all of the concerns you currently have about your child:

_____

_____

_____

_____

Which issue is of primary concern and when did it begin? _____

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

What do you enjoy most about your child? _____

What do you find most difficult about your child? _____

FAMILY ATMOSPHERE

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

Very lenient	1	2	3	4	5	Very strict
Non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Structured
Inconsistent	1	2	3	4	5	Consistent
Low expectations	1	2	3	4	5	High Expectations

Level of Family Support (from friends, relatives, church, school, etc):

Hardly any support	1	2	3	4	5	Considerable support

Circle your child's average daily amount of screen time, including TV, computer, video games, ipad and phone (games and apps) usage.

0-30 minutes 30-60 minutes 60-90 minutes 90-120 minutes 120+ minutes

If divorced from your child's other parent, circle the number that 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? _____

If your child's biological parents are divorced or separated, New Leaf Clinic is required by law to obtain a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page.

(<u>The photocopy should be stapled to this form</u>.)

GENERAL INFORMATION

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

Primary Household: (where your child spends the majority of his or her time)

Name	Relationship to client	Age

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

Name	Relationship to client	Age

INFORMATION ON CHILD'S MOTHER

Mother's Name: _____

____ biological mother ____ stepmother ____ adopted mother ____ other

Marital Status: ____ Married ____ Divorced ____ Separated ____ Single

Date of Birth: _____ /_____ /_____ Occupation: _____

Employer _____

History of emotional or behavioral problems, or learning disabilities? 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: _____

____ biological father ____ stepfather ____ adopted father ____ other

Marital Status: ____ Married ____ Divorced ____ Separated ____ Single

Date of Birth: _____ /_____ /_____ Occupation: _____

Employer _____

History of emotional or behavioral problems, or learning disabilities? Yes No

If yes, please explain: _____

History of alcohol/drug/substance abuse? Yes No

If yes, please explain: _____

CHILD'S HISTORY

For each of the following items that apply, write in your child's approximate age at the time it occurred. If not applicable to your child, leave blank.

_____ Academic problems
_____ Discipline problems
_____ Victim of bullying
_____ Bullying others
_____ Anxiety/Severe worrying
_____ Aggressive behavior
_____ Impulsive
_____ Difficulty making friends
_____ Frequent injuries
_____ Difficulty toilet training
_____ Speech/language problems
_____ Victim of abuse
_____ Chronic ear infections
_____ Asthma
_____ Chronic stomach aches
_____ Refusal to speak in certain situations
_____ Severe food aversions/refusal to eat
_____ Tics or nervous habits
_____ Obsessive thoughts/compulsive behaviors
_____ Extreme sadness/suicidal thoughts
_____ Attention problems
_____ Extremely active/as though driven by a motor
_____ Lack of Respect for Authority Figures
_____ Alcohol/drug use
_____ Aggressive toward animals
_____ Difficulty learning letters and sounds
_____ Night Terrors
_____ Eustachian tubes
_____ Chronic bedwetting (age 4 and above)
_____ Chronic headaches

_____ Major Illnesses/Hospitalizations (explain): _____

_____

_____ Other (explain) _____

CHILD'S HEALTH

Child's Primary Care Physician: _____

Address: _____

Phone number: _____

Date of LAST complete physical or "well-check": _____

Has your child been diagnosed with a physical disability or chronic illness? Yes No

(If yes, explain) _____

Does your child wear corrective lenses or hearing aids? Yes No _____

If your child is currently taking medication for physical or mental health-related conditions, please indicate the medication name, diagnosis, dosage, and date of diagnosis below.

Medication	Dosage	Diagnosis	Date of diagnosis
Medication	Dosage	Diagnosis	Date of diagnosis
Medication	Dosage	Diagnosis	Date of diagnosis
Medication	Dosage	Diagnosis	Date of diagnosis

If your child has been diagnosed with a mental health-related condition, (Depression, Anxiety, Bipolar Disorder, ADHD, etc) please indicate the name and specialty area of the diagnosing physician (Pediatrician, Neurologist, Child Psychiatrist, etc).

Name: _____ Specialty: _____ Phone: _____