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BACKGROUND INFORMATION FORM - CHILD/ADOLESCENT

I. IDENTIFYING INFORMATION

Gender: _____

Client's Name: _____ Birth Date: _____ Race: _____

Address: _____
Street *City* *State* ***Zip Code***

Telephone: (_____) _____ School District: _____ Grade _____
Area Code *Number*

School: _____ Curricula: _____ I.U.? Y N
(e.g., Regular, Learning Support, etc.) *(Please Circle)*

If client has received educational/developmental supports such as Speech, OT,PT, etc. list in Treatment section on next page

Mother's Name: _____ Birth Date: _____ Race: _____

Address and phone (if different from above): _____

Mother's Occupation: _____

Father's Name: _____ Birth Date: _____ Race: _____

Address and phone (if different from above): _____

Father's Occupation: _____

Marital Status of parents: _____ Custody: _____

Nature of contact with non-custodial parent (e.g. shared, visitation) _____

Other Adult Caretakers (if applicable) - (i.e. Step parents, parent's paramours, foster parents, etc):

Name:	Birth Date	Race	Relationship to Client

Other Family Members: (List ALL siblings, also list other family members living in client's household. Place a √ next to those living in the home.)

Name:	Birth Date	Race	Relationship to Client

II. MEDICAL HISTORY

Current Medical Condition(s): _____

Allergies: _____

Prior Medical Procedures: _____

Hx of Lead poisoning ❑ *Yes* ❑*No*

Hx of Head Injury ❑*Yes* ❑*No* Loss of consciousness ❑*Yes* ❑*No* Seizure ❑*Yes* ❑*No* Chronic/Acute Pain ❑*Yes* ❑*No*

III. TREATMENT HISTORY

County MH/MR Case Manager: _____

Primary Care Physician _____

CURRENT Treatment Providers (e.g., Mental Health, In-School Services, Developmental Specialists, etc.):

Agency	Date Begun	Contact Person/Title

Current Medication(s) - Name:	Dose	Prescribing Physician

PRIOR Treatment (Incl.Mental Health, Psychiatric Hospitalizations; Placements; Developmental Specialists, etc.):

Agency	Dates	Reason

IV. COMMUNITY SUPPORTS

Religious affiliation (optional) _____ Place of Worship _____

Employment experience:

Group/Organization	Dates

Past and Present Leisure Activities (e.g., Sports, Clubs, Camps, Extracurricular Activities, etc.):

Group/Organization	Dates

Please answer the following questions:

Any history of mental health issues in your immediate or extended family?	❑	Yes	❑	No
Any history of substance abuse in your immediate or extended family?	❑	Yes	❑	No
Any history of legal problemsin your immediate or extended family?	❑	Yes	❑	No
Any family history of domestic violence?	❑	Yes	❑	No
Any history of physical abuse towards client?	❑	Yes	❑	No
Any history of sexual abuse towards client?	❑	Yes	❑	No
Any history of neglect of client?	❑	Yes	❑	No

Please use the back of this form for information that was unable to fit in the spaces provided. Thank you.