Child/Adolescent Background Information *(use for all minors)*

COMPLETE AND EMAIL OR BRING FORM WITH YOU FOR INITIAL FIRST VISIT.
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. Feel free to ask for assistance, if needed. Your child's counselor will discuss your responses with you after he/she has reviewed the form.

*Child's Name:*_____ *Date of First Visit:* _____
Last First MI
*Completed by:*_____ *Relationship to Child:* _____
Cell Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Home Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Work Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Email Address:_____
Best Time and Place to call:_____
Child's Address:_____
Street City State Zip

(E)Child's Gender: Male__ Female__ *(F) Date of Birth* ___/___/___ *(G) Age* ____

(H)Child's Ethnicity:
African American___ Bi-racial___ Hispanic/Latino___
Asian___ Caucasian___ Native American___ Other _____

Child's primary language: English ___ Spanish ___ Other
Language spoken at home (parent's language): _____

Child's Legal Guardian (Managing Conservator)*:*
(If the child is not living with both natural 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.)

*In case of emergency, contact:*_____
Name: Last, First Relationship Phone

Is your child presently receiving counseling elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor)

Family members receiving services at this clinic? Yes No (Name/Dates of service) _____
_____

Is your child currently on probation? Yes No *School Child attends:* _____
Current School Address & Phone: _____
*Grade Level (*now): _____ *Has your child ever been retained? Yes No If yes, what grade?* _____
Current Teacher(s): 1) _____ *2)* _____ *3*_____
Current School Counselor: _____

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

Has your child ever seen a mental health professional (psychiatrist, psychologist, or a 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 were you referred to our clinic? (Check those that apply):

Counselor/Psychologist/Psychiatrist__		School personnel__
Court__	Minister___	Self__
DPRS__	Newspaper Ad__	UNT Community__
Flyer__	Physician__	Yellow Pages__
Friend or Co-Worker__	Relative___	Other_____

Are you seeking services because your child is a victim of a crime? Yes No
Did it result in legal action? Yes No *(If Yes, explain)*_____

Person responsible for financial arrangements with our clinic: _____
Name: Last, First

Are you applying for sliding scale payments? Yes No
(J)Gross Household Annual Income (including Child Support Payments)
Less than $15,000___ 16,000 – 20,000___ 21,000 – 30,000___ 31,000 – 40,000___ 40,000+___

(K)How many family members currently reside in your home? _____

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

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

I am: __ *biological mother* ___*stepmother* ___*adoptive mother* *Other*_____

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:* _____

(L)Education Level of Mother:

8th grade or below _____	Trade School/Some College ___	Undergraduate Degree ___
High School ___	GED ___	Graduate Degree ___

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) _____

History of family violence: Yes No
(If yes please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

(M)Current living arrangements:
Family of origin____ Single____ Spouse/Partner ____ Roommate____ Other____

(N)Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
Never married____ currently married____ Divorced____

(O)Marital History
Number of Marriages____ Number of Divorces____

* INFORMATION ON CHILD'S FATHER *

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

I am __ *biological father* ___*stepfather* ___*adoptive father* *other* _____

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:* _____

(P)Education Level of Father
8th grade or below _____ Trade School/Some College ___ Undergraduate Degree ___
High School ___ GED ___ Graduate Degree ___

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) _____

History of family violence: Yes No
(If yes please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

(Q)Current living arrangements:
Family of origin____ Single____ Spouse/Partner ____ Roommate____ Other____

(R)Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Never married____ currently married____ Divorced____

(S)Marital History
Number of Marriages____ Number of Divorces____

* GENERAL INFORMATION *

(T)Child's current household:
Adoptive parents ___
Father only ___
Foster family ___
Institution___
Mother only ___
Biological Father and Stepmother ___
Biological Mother and Stepfather ___
Biological Parents ___
Relatives (specify) _____
Grandparents___

List by Household your child's current family, beginning with the oldest member and include the child:
Primary Household (anyone who currently lives with child)
How long in this current living situation: _____

Name	Age	Gender	Relationship to you (include step, half, etc.)

Child lives in: House_____ Apartment _____ Duplex _____ Other_____

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

Name	Age	Gender	Relationship to you (include step, half, etc.)

Currently involved in a custody dispute: No Yes (If yes, explain) _____
_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly
1_____2_____3_____4_____5

How often does client see non-custodial parent? _____

* CHILD'S HEALTH *

Child's Primary Care Physician: _____
Name Phone

_____
Address

Has your child ever seen a psychiatrist? Yes No
Is child currently seeing a psychiatrist? Yes No (If yes, list name, address and phone):

_____
Name Phone

_____
Address

Date of LAST complete physical: _____
Physical Disability: Yes No (If yes, explain) _____
Chronic Illness: Yes No (If yes, explain) _____
Terminal Illness: Yes No (If yes, explain) _____

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	**Current** (List dates)	**Past** (List dates)	**Physician's Name**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____

Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

* CURRENT CONCERNS *

(U) **Circle the item that you see as the most significant issue for your child. Underline any additional concerns.**

Problems Related to Abuse

Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
History of family domestic violence

Academic/School Problems

Learning difficulties
Problems with peers
Problems with teachers

Mood-related Concerns

Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal ideation
Sadness
Depression
Feelings of guilt and shame
Excessive worrying

Family Relationship Concerns

Difficulty adjusting to family changes
Discipline concerns
Parent-child relationship problems
Sibling concerns
Divorce/Separation
Religious/Spiritual Concerns

Rule-Breaking/Behavior Problems

Aggression toward others
Drug/alcohol use
Truancy
Gang involvement
Running away
Stealing
Intentionally hurting animals
Fire-setting
Other unusual behaviors (please specify) _____

Other Behavioral Concerns

Sexual identity concerns
Inappropriate sexual behavior
Overeating/refusal to eat
Bedwetting or soiling
Hyperactive/Inattentive

Remember to circle the most significant issue.

*When did you first become concerned about the main/most significant issue?*_____
How have you attempted before now to deal with this issue? _____
_____

Other treatment your child has received to address any of the concerns indicated above: None___

Couples Counseling___ Group counseling___ Individual counseling___
Family counseling___ Hospitalization___ Other _____

*** HISTORY OF TRAUMA/STRESSORS RELATAED TO THE CHILD ***

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

Chronic illness of family member___ Death of significant person___ Domestic Violence____
Family member absent (explain) _____
Family member's disability/major accident/illness_____
Family member emotional problems (explain)_____
Family member suicide (explain) _____
Parent's divorced___
Child separated from parent (how long and when) _____
Death of a pet___ Difficult medical treatments___ Natural Disaster___
Sexual Assault___ Victim of trauma (unusual, terrifying experience) ___
Other_____

History of your child having learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of your child having alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity in the family: Yes No
(If yes, please explain*)* _____

Has your child been abused (check all that apply): Physically___ Emotionally___ Sexually___

Has your child been neglected (check all that apply): Physically___ Emotionally___

School Problems (check all that apply):
Academic problems___ Discipline problems___ Social Problems___ Other ___

Early Language/Speech Problems (explain) _____

History of health/physical problems includes: (check all that apply):

Asthma___ Disability___ Nervous stomach ___
Bedwetting___ Dizziness ___ Neurological problems/exam___
Bone/joint/muscle ___ Severe Headaches ___ Severe PMS ___
Chest pain ___ Heart Palpitations___ Serious overeating/under-eating__
Chronic illness___ Hospitalization___ Shortness of breath without exertion ___
Developmental delay(s) ___ Major accident___ Sleep problems___
Chronic Diarrhea ___ Major illness___ Surgeries___ Other_____

*** HOME ATMOSPHERE ***

Your child's current use of Computer, VCR, and Television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

Anything else you think we need to know? _____

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

PLEASE SUBMIT FORM TO Info@LWC.Care or fax to (817) 238-8333

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