CHILD INFORMATION PACKET

Child's Name: Date:

Date of Birth: Age: Grade:

Family :

Who does the child currently live with?

Name	Age	Relationship to Child	Job/Grade

Who are the significant others NOT residing with the child?

Name	Age	Relationship to Child	Job/Grade

History of the Concern:

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

_____

_____

_____

_____

When did you first notice the problem(s)? _____

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

_____

_____

_____

_____

When did you first notice the problem(s)? _____

Behavioral Assets:
What does your child do that you like? What does s/he do that other people like?

_____

_____

_____

_____

Has your child ever threatened/attempted to hurt or kill him/herself? ☐No ☐Yes (If yes, please explain):

_____

_____

Has your child ever threatened to or attempted to hurt others? ☐No ☐Yes (If yes, please explain):

_____

_____

Please describe any other concerns about your child below:

_____

_____

_____

_____

Treatment Goals:
Which issue would you like to address FIRST and what kinds of changes would you like to see?

_____

_____

_____

_____

Has your child been seen by a mental health professional before, or received psychiatric services before?
☐No ☐Yes (If yes, please complete grid below.)

Age	By Whom	Findings/Diagnoses	Treatments/Medications

Does your child use any of the following?
Caffeine ☐No ☐Yes (If yes, please describe frequency and amount, to your knowledge):

_____

Tobacco ☐No ☐Yes (If yes, please describe frequency and amount, to your knowledge):

_____

Alcohol ☐No ☐Yes (If yes, please describe frequency and amount, to your knowledge):

_____

Drugs ☐No ☐Yes (If yes, please describe type, frequency and amount, to your knowledge):

_____

Family Psychiatric History: Please check any of the following that exist in either side of the child's biological family, and specify which family member.
☐ ADD/ADHD; family member(s): _____
☐ Alcohol abuse; family member(s): _____
☐ Anxiety; family member(s): _____
☐ Autism Spectrum Disorder; family member(s): _____
☐ Bipolar Disorder; family member(s): _____
☐ Depression; family member(s): _____
☐ Difficulty Managing Anger; family member(s): _____
☐ Drug abuse; family member(s): _____
☐ Eating Disorder; family member(s): _____
☐ Learning Disorder; family member(s): _____
☐ Schizophrenia; family member(s): _____
☐ Other; name of problem and family member(s): _____

Have you or anyone in the family received any mental health services?
☐No ☐Yes (If yes, please explain): _____

_____

_____

Please list/describe any other stressors in your family at this time:
_____

_____

_____

Medical History:

Please check if your child has had any of the following medical problems:

☐Trouble sleeping	☐Vision problems	☐Hearing problems
☐Frequent headaches	☐Seizures	☐Unusual movements/motions
☐Fainting spells	☐High blood pressure	☐Allergies
☐Frequent stomach aches	☐Urine or kidney infection	☐Tics or other habits
☐Poor appetite	☐Cancer	☐Asthma
☐Frequent ear infections		

☐Serious head injury (if yes, please describe): _____

☐Loss of consciousness (if yes, please describe): _____

☐Surgery (if yes, please describe): _____

☐Hospitalization (if yes, please describe): _____

Is your child currently taking any medication: ☐No ☐Yes (If yes, please describe):

Medication	Dose	Prescribing Physician

Pregnancy & Early Childhood:

What was your family structure/size at the time of your child's birth?

_____

_____

Were any of the following substances used while pregnant with the child?

☐Tobacco ☐Alcohol ☐Medication (If yes, what?): _____

☐Drugs (if yes, which ones?) _____

Please check if you or your child had any of the following delivery complications:

☐Premature delivery	☐Long labor	☐Caesarian Section
☐Blue/breathing problems	☐Damage/injury	☐Fetal distress
☐Low birth weight	☐Low Apgar scores	☐Cord around neck

How do you describe your bonding experience with your child?

☐Negative ☐Average ☐Positive

How would you describe the child's temperament as a baby?

☐Good ☐Easy ☐Fussy ☐Inconsolable

How would you describe the child's temperament as a toddler?

☐Good ☐Easy ☐Difficult ☐Anxious ☐Shy

How would you describe the child's activity level as a toddler?

☐Low ☐Average ☐High

When did your child meet the following milestones?
Walking: ☐Early ☐On time ☐Late
Talking: ☐Early ☐On time ☐Late
Toilet Training: ☐Early ☐On time ☐Late

Has your child sustained or witnessed any traumas? ☐No ☐Yes (If yes, please describe):

_____

_____

Has your child suffered any type of abuse? ☐No ☐Yes (If yes, please describe):

_____

_____

Has your child had any lengthy separations from caregivers? ☐No ☐Yes (If yes, please describe):

_____

_____

Education:

What school does the child attend?_____

Current grade: _____ Has the child repeated a grade? ☐No ☐Yes (If yes, which one(s): _____

Please check if your child has had any of the following educational problems:
☐Poor grades ☐Speech problems ☐Doesn't bring homework home
☐Reading problems ☐Math problems ☐Spelling problems
☐ Poor handwriting ☐Disorganized ☐Messy ☐Forgets to hand in homework

Does your child have an active IEP? ☐No ☐Yes (If yes, please explain):

_____

_____

Has your child ever received special education services? ☐No ☐Yes (If yes, please explain):

_____

_____

Please describe any other educational/school problems your child has:

_____

_____

How would you describe your child's social skills?
☐Excellent ☐Good ☐Average ☐Poor
☐Problems making and keeping friends ☐Makes friends but has difficulty keeping them