

BACKGROUND INFORMATION FORM
FOR PARENTS



So that I can help you, please fill out the following information about your child. Be assured that this information will be treated in a professional manner.

Appointment scheduled: Yes/No _____

If yes, please supply date: _____

Child's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: *(home)* _____ *(parent work or cell)* _____

Date of Birth: _____ Age: _____ Grade: _____ Sex: _____

School Name/District: _____

Name of parent or guardian: _____

Name of person filling out this form: _____

What is your relationship to this child? _____

How did you hear about me? _____

What is currently happening in your child's life that led you to contact me?

When did these situations or problems first begin?

Have you received any previous help for this?

What kind? _____

When? _____ Where? _____

With whom? _____ Was this helpful? _____

How?

What procedures have you tried on your own?

What are the desired outcomes of our work? If you are seeking evaluation, what questions do you hope to have answered?

What sudden changes have you noticed recently in the child's behaviors and moods, or in family members?

What important things have happened to the child or the child's family in the last six months?

SCHOOL HISTORY

What schools has this child attended?

What grade is this child in now?

At what school? _____

In what three subjects does this child earn the best grades?

1. _____

2. _____

3. _____

In what three subjects has this child earned the lowest grades?

1. _____

2. _____

3. _____

What advanced placements or other educational adaptations has this child received?

Is this child's schoolwork currently Above Average, Average, or Below Average?

What are his/her favorite subjects?

What special school problems does this child have?

What psychological or achievement tests has this child had previously?

What were the results or scores? Attach reports if available.

How does this child's teacher describe his/her behavior at school?

MEDICAL AND DEVELOPMENTAL HISTORY

What aches, pains or physical discomforts does this child have?

What has he/she been hospitalized for in the past?

What prescription and/or non-prescription medication is this child currently taking?

Please put an "X" by any of the following that your child has experienced:

- | | |
|-------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> a. Allergies | <input type="checkbox"/> l. Overweight |
| <input type="checkbox"/> b. Asthma | <input type="checkbox"/> m. Poor bowel control |
| <input type="checkbox"/> c. Bedwetting | <input type="checkbox"/> n. Nightmares |
| <input type="checkbox"/> d. Bladder Infections | <input type="checkbox"/> o. Sleep problems |
| <input type="checkbox"/> e. Constipation | <input type="checkbox"/> p. Stomach Aches |
| <input type="checkbox"/> f. Ear Infections | <input type="checkbox"/> q. Stuttering |
| <input type="checkbox"/> g. Eating Problems | <input type="checkbox"/> r. Teeth grinding |
| <input type="checkbox"/> h. Epilepsy | <input type="checkbox"/> s. Underweight |
| <input type="checkbox"/> i. Small-motor coordination difficulties | <input type="checkbox"/> t. Unusual vomiting |
| <input type="checkbox"/> j. Gross-motor difficulties | <input type="checkbox"/> u. Vision problems |
| <input type="checkbox"/> k. Headaches | <input type="checkbox"/> v. Infections |

Please tell me about each one you've marked and any additional medical history
In general, how would you describe this child as an infant?

Please endorse any that apply:

Pregnancy:

- | | |
|------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Falls | <input type="checkbox"/> Emotional stress |
| <input type="checkbox"/> Excess bleeding | <input type="checkbox"/> Lack of prenatal care |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Alcohol/drug use |
| <input type="checkbox"/> Toxemia/Pre-eclampsia | <input type="checkbox"/> No complications of pregnancy noted |

Labor:

- | | |
|--------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Spontaneous | <input type="checkbox"/> Complicated |
| <input type="checkbox"/> Induced | <input type="checkbox"/> No complications of labor |
| <input type="checkbox"/> Protracted | |

Delivery:

- | | |
|--------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Premature | <input type="checkbox"/> Caesarean |
| <input type="checkbox"/> Post-mature | <input type="checkbox"/> Complicated delivery |
| <input type="checkbox"/> Breech | <input type="checkbox"/> No complications delivery |

Neonatal Factors:

- | | |
|----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Birth injury/defect | <input type="checkbox"/> Breathing problems |
| <input type="checkbox"/> Jaundiced | <input type="checkbox"/> No neonatal problems |
| <input type="checkbox"/> Low birth weight | |

At What Age Did This Child:

Sit alone _____ Complete toilet training _____
 Crawl _____ Use two words together _____
 Walk alone _____ Read _____
 Say his/her first word _____ Learn to add _____
 Learn basic colors _____

HOME HISTORY

Please fill in the names, ages, etc., of this child's family.

	NAME	AGE	LEVEL OF EDUCATION	OCCUPATION	WHERE EMPLOYED	WORK SCHEDULE
FATHER						
MOTHER						
BROTHERS AND SISTERS						
OTHERS LIVING IN THE HOME <i>(please indicate relationship to the child)</i>						

(If any of the above were adopted, please indicate this)

Who disciplines the children, and how?

Marital status of parent(s): _____

What strengths and problems are there in the relationship between the child's parents?

Please put an "X" by any of the following that are a problem with this child?

- | | | |
|------------------------------------------------|---------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> 1. Anxiety/tension | <input type="checkbox"/> 11. Withdrawn | <input type="checkbox"/> 21. Lying/dishonesty |
| <input type="checkbox"/> 3. Tiredness/fatigue | <input type="checkbox"/> 13. Fears/phobias | <input type="checkbox"/> 23. Temper tantrums |
| <input type="checkbox"/> 4. Self-Critical | <input type="checkbox"/> 14. Rituals | <input type="checkbox"/> 24. Head banging |
| <input type="checkbox"/> 5. Easily upset | <input type="checkbox"/> 15. Nail Biting | <input type="checkbox"/> 25. Destructiveness |
| <input type="checkbox"/> 6. Overly sensitive | <input type="checkbox"/> 16. Thumb sucking | <input type="checkbox"/> 26. Running away |
| <input type="checkbox"/> 7. Easily frustrated | <input type="checkbox"/> 17. Jealousy/resentment | <input type="checkbox"/> 27. Drug/alcohol |
| <input type="checkbox"/> 8. Shyness | <input type="checkbox"/> 18. Overactive | <input type="checkbox"/> 28. Sexual Problems |
| <input type="checkbox"/> 2. Depression/sadness | <input type="checkbox"/> 12. Obsessive/Ruminative | <input type="checkbox"/> 22. Stealing |
| <input type="checkbox"/> 9. Over-dependency | <input type="checkbox"/> 19. Underactive | <input type="checkbox"/> 29. Cruelty |
| <input type="checkbox"/> 10. Guilt feelings | <input type="checkbox"/> 20. School problems | <input type="checkbox"/> 30. Clumsiness |

Please tell me a little bit about each one you marked.

What are this child's strong points, favorable characteristics or "good" behaviors?

What games or particular interests does this child enjoy?

What else does this child like to do?

What kinds of things might serve as rewards or motivations for this child?

How does he/she get along with teachers as compared with his/her parents?

How does he/she get along with boys and girls of the same age?

How does he/she get along with older playmates or adults?

How many close friends does the child have? _____

What people has this child felt close to in his/her life?

FAMILY HISTORY

What emotional problems (e.g., *nervous breakdown, depression, etc.*) have there been in the child's family or relatives?

What medical/physical problems have there been in the child's family or relatives (*include conditions like ADHD, whether or not they are treated with medication*)?

GENERAL

Do you think this child would be helped more by: (Please mark with an "X")

- Counseling with the parents
- Counseling with the teachers
- Psychological testing
- Receiving medicine
- Directions to change specific behaviors
- Talking about his/her problems individually
- Group sessions
- Other (explain)

ADDITIONAL INFORMATION

Please list all psychologists, physicians, speech therapists, clinics, etc., who have had contact with this child. Also, please tell me any other significant or interesting facts about this child. Feel free to use the next page, if needed.

Thank you for your time. Please complete this form and either return it via email (info@amendpsych.com) or print and return it to the address above.

ADDITIONAL INFORMATION (cont.)

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