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About my child Form:

Name: ______________________________ Date: ______________

Name of child: ______________________ Relationship to child: ☐mother ☐father ☐other

Your child Information:

Please explain your reasons for seeking out treatment now?

What are the primary issues your child faces?

Does your child exhibit any emotional, psychological or behavioral difficulties?

If yes, please describe:

Child's **past** behavioral/emotional history:

- ❑ Worry/Panic
- ❑ Obsessions/Compulsions
- ❑ Alcohol/Drug use
- ❑ Depression/mood swings
- ❑ ADHD
- ❑ Non-adherent
- ❑ Anger/Aggression
- ❑ Tics/other

Check any of the symptoms that your child is **currently** having:

- ❑ Depression
- ❑ Extreme sadness
- ❑ Trouble concentrating
- ❑ Memory problems
- ❑ Change in eating habits
- ❑ Feeling of extreme happiness
- ❑ Trouble performing your job
- ❑ Lack of enjoyment of usual activates
- ❑ Self-esteem problems
- ❑ Perfectionism
- ❑ Obsessions or compulsions
- ❑ Feeling fearful
- ❑ Physical complaints of pain
- ❑ Problems with anger
- ❑ Feeling hopeless
- ❑ Feeling tearful
- ❑ Change in sleeping habits
- ❑ Lack of energy
- ❑ Weight changes
- ❑ Excessive anxiety or worry
- ❑ Problems getting along with friends or family
- ❑ Feeling stressed
- ❑ Easily irritated
- ❑ Feeling guilt
- ❑ Feeling nervous
- ❑ Sudden feelings of panic
- ❑ Muscle tension
- ❑ Acting violently

Received by: ______________________________ Date:________

Do you think your child would ever hurt him/herself?
If yes, do you think he/she has a plan?

Do you think your child would ever hurt someone else?
If yes, please describe?

Stressful Circumstances:
Did your child (and you) experience any stress recently and during your child's lifetime? (Examples: conflict with family/friend, financial problems, death, divorce, and illness)
If yes, please explain when and what.

Has your child ever been physically abused?
If yes, is it still going on?

Has your child ever been sexually abused?
If yes, is it still going on?

Medical and Health Information:
How would you describe your child's eating habits?
- ❑ Healthy (I eat pretty good)
- ❑ Average (I probably need to change some things)
- ❑ Needs some help (I eat a lot of junk)

How often do your child exercise? What type of activities do they do?
- ❑ Daily
- ❑ 3-5 times a week
- ❑ 1-2 times a week
- ❑ Less than once a week

Received by: ____ Date:________

Education/Work History:

Does your child have any learning difficulties or attention issues?

If yes, please list or describe:

Any problems in school with:

- ❑ Grades
- ❑ Learning
- ❑ Peer relations
- ❑ Behavior
- ❑ Other: ____________________

Does your child have any problems at work?

If yes, please describe:

Social Information:

Who are your child's close friends?

Are there any concerns you have about his/her friends?

Is your child currently in a serious one-on-one relationship?

Parent/child relationship:

How would you describe your relationship with your child?

What would you like to change about your relationship with your child?

What have you already tried?

What happened when you tried these things?

Received by: ____________________ Date:________

Parent Personal Information:

How would you describe yourself?

Check any of the symptoms that you are having:

- ☐ Depression
- ☐ Extreme sadness
- ☐ Trouble concentrating
- ☐ Memory problems
- ☐ Changes in eating habits
- ☐ Feeling of extreme happiness
- ☐ Trouble performing your job
- ☐ Lack of enjoyment of usual activities
- ☐ Self-esteem problems
- ☐ Perfectionism
- ☐ Obsessions or compulsions
- ☐ Feeling fearful
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- ☐ Feeling guilt
- ☐ Feeling nervous
- ☐ Sudden feelings of panic
- ☐ Muscle tension
- ☐ Acting violently

Have you ever thought of hurting yourself?

If yes, do you have a plan?

Have you ever thought of hurting someone else?

If yes, do you have a plan?

Have you ever been physically abused?

If yes, is it still going on?

Have you ever been sexually abused?

If yes, is it still going on?

Medical & Health information:

How would you describe your health? (eating habits, exercise, etc.)

Previous and current health problems or illnesses:

Previous and current medications:

Received by: ______________________ Date:________

Substance Use History:

Do you drink alcohol?

If yes, how often:

Do you use drugs?

Do you smoke cigarettes?

Employment:

Where do you work? ________________________ How many hours a week? __________

What do you do?

Do you like what you do?

Do you have any problems there?

Relationship Information:

Are you married?

If yes, to whom: ________________________ when (date): ________________

Do you have any children from this marriage?

If yes, what are their names & ages:

Have you been married before?

If yes, do you have any children from that marriage?

Do you have children from another relationship?

Do you currently have a significant other?

If yes, please describe your relationship:

Received by: ____ Date:________

Parenting Information:

How would you describe your parenting style?

When does your style work & when doesn't it work?
How would you describe your partner's parenting style?

When does it work & when doesn't it work?

Do you disagree about parenting styles?

Family Information:

Parent(s) (please list names, ages, and where they are currently living)

How would you describe your parents' relationship?

Are you adopted?

How many siblings do you have? (please list names, ages, and where they live now)

Describe your relationship with the following:

Parents/step-parents/guardians:

Brothers and/or sisters:

Extended family (grandparents, aunts, uncles, cousins)

Received by: ____ Date:________

Family History:
Has any family member had any of the following? If yes, who, when and how were they treated?

Anxiety/Panic: ____________________
Obsessions/Compulsions: ____________________
Substance abuse: ____________________
Depression/mood swings: ____________________
Anger/aggression: ____________________
Schizophrenia: ____________________
Suicidal behavior: ____________________
Other conditions: ____________________
Any major illness: ____________________

Received by: ____________________ Date: ________