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# Child & Adolescent Background Information Form

Thank you for taking the time to complete this form and bringing it with you to your initial appointment. The information you provide will enable your child's therapist to have a better understanding of your child and will help in his or her evaluation and treatment.

Today's Date: ____________________

Child's Name: __________________________________________________ Age: _______
Last First Middle

Date of Birth: ______________ Sex: __________ Race/Ethnicity: ___________________
Religion: ____________________
School Child Attends: ___________________________________ Grade: _____________
School's Address: ____________________________________________________________
School's Phone #: __________________________ Fax #: ___________________________
Teacher's Name and number/email:

______________________________________________________________________________
Guidance Counselor's Name number/email:

______________________________________________________________________________

Mother's Name: _______________________________________________________________
Home Phone: _____________________ Cell Phone: _______________________________
Email Address: _______________________________________________________________
What is your preferred method of contact? ____________________________________
Employer: _________________________________ Work Phone: ______________________

Father's Name: ________________________________________________________________
Home Phone: _____________________ Cell Phone: ________________________________
Email Address: ________________________________________________________________
What is your preferred method of contact? _____________________________________
Employer: _________________________________ Work Phone: _______________________

Marital Status of Parents: _______________________________
If divorced/separated, child lives with: Mother _____% of time Father ______ % of time
Who has legal custody of this child? __________________________________________
Has non-custodial parent been informed of this treatment or evaluation?
_____ Yes _____ No
*If shared legal custody, non-custodial parent must sign all release forms and consent to treatment forms.*

Name of Child's Pediatrician/Family Doctor: ___________________________________ Referred by: __
_______________________________________ Phone: __________________

REASON FOR REFERRAL:
Please list your presenting concerns related to this child. If you are requesting a psychological evaluation, please let us know what questions you hope to have answered by this evaluation.
_______________________________________________________________ ____________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Attempted Solutions:
_________________________________________________________________ __________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

List all schools previously attended and dates of attendance:
School: ______________ Location: ___________ Grade(s): _____ Dates: ______
School: ______________ Location: ___________ Grade(s): _____ Dates: ______
School: ______________ Location: ___________ Grade(s): _____ Dates: ______

Has your child ever been retained or skipped a grade? _____ Yes _____ No
If yes, please explain. ____________________________________________________

Has your child ever received Special Education services or have an IEP through the school?
_____ Yes _____ No
If yes, what classification is listed on the IEP and what services are provided?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

**Please bring copies of your child's previous evaluations, IEPs, and most recent report cards.**

FAMILY MEMBERS (please include parents, grandparents, other guardians & siblings):
Name: ____________ Age: ______ Relationship: ______ Occupation: __________
Lives In/Out Home: ________________ Highest Grade Completed: ______________

Name: ____________ Age: ______ Relationship: ______ Occupation: __________
Lives In/Out Home: ________________ Highest Grade Completed: ______________

Name: ____________ Age: ______ Relationship: ______ Occupation: __________
Lives In/Out Home: ________________ Highest Grade Completed: ______________

Name: ____________ Age: ______ Relationship: ______ Occupation: __________
Lives In/Out Home: ________________ Highest Grade Completed: ______________

If any of your children were adopted, please note below.
__________________________________________________________________________________
__________________________________________________________________________________

Please note if there have been previous marriages, or if there have been any deaths in the immediate family.

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Please list medical or mental health professionals currently or previously consulted:
Name: ____________________ Date: ______ Phone & Fax: ______________________
Name: ____________________ Date: ______ Phone & Fax: ______________________
Name: ____________________ Date: ______ Phone & Fax: ______________________

**If you have reports, treatment summaries, or other documents from these professionals, please bring copies with you.**

Please describe your child's medication history:
Medication: _____________ Dosage: ________ Start/Stop Date: ___________________
Prescribed By: _____________________

Medication: _____________ Dosage: ________ Start/Stop Date: ___________________
Prescribed By: ________________________________________________________________
_______________________________________________________________________________

Please note any previous psychological evaluations of your child:

Date: _____________ Tests Given/Type of Evaluation: ___________________________
Reason for Referral: _____________________ Examiner: __________________________
_______________________________________________________________________________

Date: _____________ Tests Given/Type of Evaluation: ___________________________
Reason for Referral: _____________________ Examiner: __________________________
_______________________________________________________________________________

**Please bring copies of any previous psychological evaluations.**

Please list your child's greatest strengths:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Please list the family's greatest sources of stress:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Please tell us anything you think might be important for us to know about your child, your family, or any exceptional circumstances that might directly or indirectly affect your child:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

What do you hope to accomplish by bringing your child in for treatment and/or evaluation at this time?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Is there anything else you would like for us to know about your child or your family?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

This form was completed by: ________________________________________

Date: ________________________

PERMISSION TO TREAT:

I am legally authorized as the parent/guardian of ____________________________ to enroll him/her in psychological services. I hereby authorize Dr. Sandra Henderson of Tuckahoe Child Psychology, PLLC to provide psychological treatment and/or evaluation for __________________________________________-_________________________________.

Client's name: _____________________________________________ DOB: _______________

Client's signature: ______________________________________________________________

Minor Guardian's Parent's Name: ________________________________ DOB: ___________

Minor Guardian's Parent's Signature: ______________________________________________

Date: ___________________