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Minor Background History

Name of Child	
Parent's Names	
Guardian's Names (if different)	
Who completed this form?	
Birthdate	
Age	
Date of Appointment	
School	
Grade	
Gender	
Ethnicity	

Which behaviors is your child struggling with most?

What are your child's strengths?

Please describe any life changes that could be affecting your child:

Languages Spoken in the home:___________________________________

Social History:

Please list places your child has lived:

Location	Dates or Ages

Please list your child's sisters and brothers:

Name	Age/Grade	Learning problems?		Mental Health difficulties?		Relationship?		
		Yes	No	Yes	No	Poor	Fair	Good
		Yes	No	Yes	No	Poor	Fair	Good
		Yes	No	Yes	No	Poor	Fair	Good
		Yes	No	Yes	No	Poor	Fair	Good

Who currently lives in the family home?

Relationship with Father: N/A Poor Fair Good

Relationship with Mother: N/A Poor Fair Good

Biological Father's Job:______________________ Biological Mother's Job:_________________________

Are the child's parents married? Yes No

If No, are they divorced or separated? Yes Never Married

If divorced or separated please describe current parenting plan and relationship status of both parents?

Parent Time with Father: Frequency:_______________Length of Visits:_______________

Parent Time with Mother Frequency:_______________Length of Visits:_______________

Does the child have step-parents? Yes No Names:____

Relationship with Step-Father: N/A Poor Fair Good

Relationship with Step-Mother: N/A Poor Fair Good

Step-Father's Job:_____________________ Step-Mother's Job:____________________________

Circle any of the following that have been present in your child's immediate/extended family members:

Heart Disease/Attack	Stroke	Cancer	Intellectual Impairment
Learning Problems	Anxiety	Depression	Social Difficulties
ADHD	Autism/Asperger's	Alcoholism	Drug Addiction/Abuse
Bipolar Disorder	Personality Disorders	Jail/Prison	Probation
Suicide	Extended Unemployment	Eating Disorder	Developmental Delays
Tic Disorders	OCD	Schizophrenia	PTSD
Sleep Disorders	Sexual Disorders		

Does your child attend a religious organization regularly? Yes No Where_______________

Do any close family/friends in the area to provide support to your family and child? Yes No

Has your child ever been in trouble with the law/juvenile services? Yes No

If so, please list offenses and outcome

Who is in charge of discipline in the home?

Do all caregivers agree on discipline procedures in the home? Yes No

Describe discipline strategies that are used:

What are your child's chores and responsibilities?

History of Trauma (circle all that apply):

Serious Illness in Family	Sexual Abuse	Victim of Violence
Serious Illness in Child	Exposure to Domestic Violence	Unsafe Neighborhood
Poverty	Child Abuse/Neglect	Homeless
Multiple Caregivers	Foster Care/Adopted	

Have the child's parents or guardians ever been on probation? Yes No

Have the parents or guardians ever served time in jail or prison? Yes No

Has the Department of Children & Families (DCF) ever been involved with your family? Yes No

Explain:

Has the child ever been placed outside of his/her home? Yes No

Explain:

Please circle any of the following mental health symptoms that your child often struggles with:

Irritable	Sad most of the day	Excessively nervous	Difficulty separating from parents
Poor attention to detail	Paying attention for long periods	Poor organization	Easily distracted
Does not listen when spoken to directly	Fails to finish work	Often loses things	Forgetful
Loss of interest in normally enjoyable activities	Refuses to attend school	Frequent mood changes	Purposefully injures self or cutting self
Mistrustful of others	Defiant	Low self-esteem	Sleeps with parents
Test anxiety	Impulsive	Social anxiety	Strong beliefs that are unsupported by reality
Sees or hears things that are not present	Talks about suicide	Unemotional	Obsessions
Lack of remorse	Suicide attempt	Phobia with ____________________________	
Fidgets	Restless	Physical aggression	Verbal aggression
Argues with adults	Cruel to animals	Steals	Hyper
Sexually inappropriate	Trespassing	Interrupts others	Leaves house without parent permission
Runs away from home	Ritual/unusual routines	Difficulty remaining quiet	Hostile

Excess spending	Risky or illegal behavior	Talks excessively	Overly dramatic
Anger Management	Poor coping	Inflated self-esteem	Blames others for their mistakes
Lying	Anxious	Bizarre thinking	Procrastination
Panic Attacks	Hoarding	Lacks Motivation	Withdrawn

Circle any of the following harmful eating behaviors that your child struggles with:

Refuses to eat in front of others	Induces vomiting after meals	Overly restrictive diet	Exercises right after meals
Uses diuretics	Purposefully fasts	Binge eats	Overly picky eater

Circle any of the following social skills which are difficult for your child:

Eye contact when not in trouble	Does not initiate interactions with peers	Lack of desire to share enjoyment in activities	Does not understand give and take of social relationships
Lacks empathy	Lack of age-appropriate pretend/make believe	Accepting criticism	Bossy
Inappropriate comments	Does not take turns	Does not share	Bragging
Able to hold conversations	Overly shy	Inflexible with routines/rules	Difficulty adjusting to change
Few close friends	Overly affectionate with strangers	Difficulty forming attachments with caregivers	Does not seek comfort when upset
Difficulties with social chit-chat	Bullies or taunts others	Misinterprets others' intentions	Unusual interests for age

Circle any communication difficulties which affect your child:

Not using eye contact to interact with others	Problems reading facial expressions	Using nonverbal gestures to convey meaning	Difficulty expressing self effectively
Stutters	Facial expressions don't match emotions	Speaks in an odd voice	Speaks too loud
Speaks too softly	Invades personal space	Difficulty with pronunciation	Verbal tics
Does not speak in everyday situations	Unusual rate of speech	Uses words that have no meaning	Curses excessively
Talks too much	Talks too little	Yelling	

Circle any sensory difficulties that your child struggles with:

Waves hands in front of face	Refuses to eat foods with certain textures	Rocks while seated	Twisting or ringing hands
Looks at things too closely	Often looks at things out of the corner of their eye	Overly sensitive to loud noises	Under-responsive to loud noises
Motor tics	Refuses to wear certain fabrics	Only eats certain foods	Preoccupied with lights or parts of objects

What does your child do for fun?

Does your child make and maintain friendships easily? Yes No

If no, please explain:

Does your child often spend time with friends outside of school? Yes No

Quality of Relationships with Peers: Poor Fair Good

Developmental History:

Was your child's pregnancy normal? Yes No

If no, explain complication?

Premature	Low Birth Weight	Gestational Diabetes	Jaundice
C-Section	Mom drank alcohol	Mom smoked	Mom used illegal drugs

Was your child's delivery normal? Yes No

If no, explain complication?

Number of days in hospital following birth?_____

When did your child reach the following developmental milestones?

First Steps:______________ Toilet training:________

First Words:_____________

Describe any unusual development:

Infant Temperament (circle all that apply): Easy to Soothe Withdrawn

Under-responsive Fussy Difficult to Soothe Happy

Is your child's vision normal? Yes No If not, what type of corrective lenses do they use?

Is your child's hearing normal? Yes No If not, what type of corrective device do they use?

Has your child ever had surgeries? Yes No If so, please describe.

Has your child ever been hospitalized? Yes No

If so, what happened and when?

Place an "X" next to any medical diagnosis that your child has received:

Medical Disorder	Birth to age 12	As an adolescent
Failure to Thrive		
Chronic Ear Infections		
Lead Poisoning		
Cancer		
HIV/AIDS		
Concussion		
Seizure/Epilepsy		
Digestion Issues		
Broken Bones		
Chronic Stomach Problems		
Asthma		
Meningitis		
Head Injury		
Genetic disorder		
Other Illness________________		

History of Treatment Services:

Practitioner	*Name/Organization*	*Dates*	*Treatment/Duration*
Psychiatrist			
Pediatric Neurologist			
Occupational Therapist			
Speech Therapist			
Physical Therapist			
Mental Health Services	1. 2. 3.		
Other Specialists:			

Circle any of the following that your child often struggles with:

Headaches	Fainting	Sleeps too little	Sleeps too much
Seizures	Nausea	Eats too much	Eats too little
Stomachaches	Vomiting	Diarrhea	Constipation
Heart racing	Chest pains	Excess sweating	Shallow breathing
Tension	Sore throat	Bed wetting	Bed soiling
Hair pulling	Nail biting/picks skin	Wets self	Soils self

Circle any motor difficulties that your child has/had:

Clumsiness	Awkward gait	Poor fine motor	Difficulty learning to ride a bike
Difficulty throwing or catching	Difficulty skipping	Not athletic	Difficulty coordinating movements
Poor Handwriting	Trouble learning to tie shoes	Poor balance	Poor muscle tone

Circle any mental health disorder in which your child has been diagnosed:

Depression	Learning Disability	Obsessive Compulsive Disorder	Bipolar Disorder
Schizophrenia	Intellectual Impairment	Substance Abuse	Autism/Aspergers
Manic	Oppositional Defiant	Attachment issues	Tic Disorder
Anxiety/PTSD	Conduct Disorder	Personality Disorder	ADHD/ADD
Sleep Disorder	Speech/Language Issues	Developmental Delays	Eating Disorder
Other			

Has your child ever been diagnosed with any other disorders? Yes No

Please explain diagnoses ____

Please list any previous medications:____

____

Please list any current medications:____

____

Educational History:

Did your child attend Preschool? Yes No If so, where?_________________

What is your child's current grade? ________

Please list the schools that your child attended:

School	City and State	Grade

Circle how well your student typically does in each of the following subjects:

Math	D or F	C	B	A
Language Arts	D or F	C	B	A
Social Studies	D or F	C	B	A
Science	D or F	C	B	A
Art	D or F	C	B	A
Gym/PE	D or F	C	B	A

Circle any of the following which have been problematic for your child over the past year:

Failing grades	Detention	Suspension	Expulsion
Physical fights	Bullying others	Victim of bullying	Refuses to do homework
Drugs	Alcohol	Skipping school	Conflict w/teachers
Off-task behavior in class	Cigarettes	School refusal	School/Test Anxiety
Poor School Attendance	Several Changes of School times	Forgets Homework	Loses Planner

Has your child ever been retained in or repeated a grade? Yes No If so, what grade(s)?_____

Does your child have an individual education plan (IEP)? Yes No

Does your child have a 504 plan? Yes No

If so, circle all classifications/disabilities that apply:

Reading learning disability	Math learning disability	Writing learning disability	Speech/Language impaired
Hearing impaired	Visually impaired	Emotional disturbance	Intellectual Impairment
Autism/Asperger's	Traumatic Brain Injury	Medical impairment	Other Health Impairment
Physical Therapy Impairment	Occupational Therapy Impairment	Developmental Delay	Hospital/Homebound

What special services or accommodations do they receive at School? Mark all that apply.

Extended time on tests	Tests taken in a quiet space	Tests taken in small group	Additional time to complete assignments
Intensive Reading	Intensive Mathematics	Social-Communication Classroom	Behavior Unit Classroom
Intensive English/Language Arts	Speech or Language Therapy	Occupational Therapy	Physical Therapy
Shortened Assignments	Subjects taught below grade level curriculum	Exempt from state-wide standardized tests	Functioning Living Skills Classroom

Has your child started the Response to Intervention (RTI) or Multi-Tiered Systems of Support (MTSS) process? Yes No

If so, which tier is he/she in? Tier I Tier II Tier III

What current intervention is being used?

In which after school activities does your child participate?

Future Educational/Career Goals:____

If Applicable, complete:

Is your son/daughter dating? Yes No

Is your child sexually active? Yes No Don't Know

Do you have concerns about internet use or abuse? Yes No

To the best of your knowledge, does your child use any of the following?

Alcohol, PCP (angel dust), marijuana, amphetamines (speed), cocaine, crack cocaine, hallucinogens (acid, mushrooms), ecstasy, methamphetamine (meth), opium, heroin, sleeping pills, pain killers

Last used:____

Do you have any concerns about video game addiction? Yes No