Behavioral Diagnostics & Treatment

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Child & Family Information *(Parent to Complete)*

Today's Date: ____/____/____ Person Completing this Form: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Step Mother ☐ Step Father ☐ Other _____

Preferred Phone: ____-____-_____ Alternate Phone: ____-____-_____ Email: _____@_____

Is it ok to include you in our database for occasional news or follow-up? ☐ Yes ☐ No

If divorced, is the custody joint? ☐ Yes ☐ No ☐ N/A

If divorced, are you the custodial parent? ☐ Yes ☐ No ☐ N/A

If not, please list custodial parent name: _____ Phone: ____-____-_____

Can you provide a copy of the custody order? ☐ Yes ☐ No ☐ N/A

Child/Teen Name: _____ Birth Date: ____/____/____ (Age: ____)

Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Child/Teen School:_____ Grade:_____ Teacher Name:_____

Mailing Address: _____ City: _____ Zip: _____ Phone: ____-____-_____

Ethnic Background: _____ Is Child Adopted? ☐ Yes ☐ No If yes, age at adoption: _____

Child's Religion:_____ How often does child attend services? _____

How many times have you moved since this child's birth? _____

Referral Initiated by: _____

Main concerns about your child/teen: _____

What goals do you have for assessment or treatment?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Parent	Name	Age	Occupation	Race	Education	Contact with Child
Mother:	_____	____	_____	_____	_____	_____
Father:	_____	____	_____	_____	_____	_____
Stepmother:	_____	____	_____	_____	_____	_____
Stepfather:	_____	____	_____	_____	_____	_____

Other Children in Family: Name	Age	Sex	Grade	How is School Going?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Others Living in Household: Name **Age** **Sex** **Relationship to Patient**

_____ _____ _____ _____

_____ _____ _____ _____

Early Developmental History

Pregnancy & Child Birth

Did you have anything unusual happen during pregnancy? _____

Did you smoke, drink, or use drugs during your pregnancy? _____

If yes, please specify frequency, amount, name: _____

Labor and Delivery: Did anything unusual occur during labor or delivery? _____

Birth weight: _____ Birth length: _____ APGAR Score: _____

Infancy:

Was special care required as a newborn? ☐ Yes ☐ No; If so, what? _____

Was your child re-admitted to the hospital in the first months? ☐ Yes ☐ No; If so, when? _____ How long? _____

What did you enjoy most about your child as an infant? _____

What was difficult about your child as an infant? _____

As an infant, was your child:

- Predictable? ☐ Yes ☐ No; Provide details, if desired: _____
- Unpredictable? ☐ Yes ☐ No; Provide details, if desired: _____
- Easy to parent? ☐ Yes ☐ No; Provide details, if desired: _____
- A challenge to parent? ☐ Yes ☐ No; Provide details, if desired: _____
- Further comments: _____

Developmental Milestones

Does your child show a hand preference? ☐ Yes ☐ No; ☐ Right ☐ Left At what age?_____

All developmental stages attained within normal limits? ☐ Yes ☐ No

Sat unsupported at ____ months Bladder trained at ____ months

Bowel trained at ____ months Dry bed after ____ months

Walked unsupported at ____ months First words at ____months

Anything occur ages 0-3 years in child's life you thought might affect normal growth, development, or school success?

_____

Health Care History

Physician/Pediatrician: _____ Phone: ____-____-_____ ext. _____

Psychiatrist/Nurse Practitioner: _____ Phone: ____-____-_____ ext. _____

Has your child taken daily medication for an extended period? ☐ Yes ☐ No *(If yes, list below)*

Is your child taking medication now? ☐ Yes ☐ No *(If yes, list below)*

Current Medications: Who prescribes the medication(s)? Dr._____ Dr. _____ Dr. _____

☐ Adderall_____ mg ☐ Adderall XR _____ mg ☐ Concerta _____ mg

☐ Cylert _____ mg ☐ Cymbalta _____ mg ☐ Dexedrine_____ mg

☐ Effexor _____ mg ☐ Focalin _____ mg ☐ Intuniv _____ mg

☐ Prozac _____ mg ☐ Ritalin _____ mg ☐ Tenex _____ mg

☐ Vyvanse _____ mg ☐ Wellbutrin _____ mg ☐ Other _____ mg; List: _____

Does your child have any problems sleeping now? ☐ Yes ☐ No _____

How many hours does your child sleep per night? ___ hours, on average

Does your child have a hard time getting up? ☐ Yes ☐ No _____

Does your child have any problems with eating? ☐ Yes ☐ No _____

Did your child have any problems in the past? ☐ Yes ☐ No _____

Previous Illnesses *(check all)*	**Year**	**Previous Illnesses**	**Year**
☐ Meningitis	_____	☐ Hearing/vision problems	_____
☐ Encephalitis	_____	☐ Concussion/skull fracture	_____
☐ Recurrent earaches	_____	☐ Ingestion of poison	_____
☐ Recurrent respiratory	_____	☐ Reaction to drugs	_____
☐ Infections	_____	☐ Allergies	_____ List: _____
☐ Seizures (Epilepsy)	_____	☐ Loss of consciousness	_____
☐ Growth problems	_____	☐ Concussion(s)	_____
☐ Tires too easily	_____	☐ Type 1 Diabetes	_____
☐ Type 2 Diabetes	_____	☐ A.D.H.D./A.D.D.	_____

Has your child been treated for psychological problems? ☐ Yes ☐ No If so, when? _____ For what?_____

☐ Outpatient ☐ Inpatient **Treatment Type:** ☐ Individual ☐ Family ☐ Medications ☐ CBT ☐ Behavior Therapy

Treatment Providers: _____

Current & Past Behavioral Concerns

Please indicate concerns you have/had about your child NOW (N) in the PAST (P), or for BOTH (B).

___ Not minding	___ Lack of friends	___ Stealing	___ Excessive video game time
___ Temper tantrums	___ Unacceptable friends	___ Moodiness	___ Excessive screen time
___ Clumsiness	___ Arguing	___ Disorganization	___ Excess social media time
___ Nightmares	___ Memory problems	___ Difficulty sleeping	___ Lying about video, screen, or social media
___ Low self-esteem	___ Lying	___ Frequent crying	___ Other Behaviors _____
___ Giving up easily	___ Drug use	___ Verbal fighting	
___ Alcohol use	___ Hitting	___ Tobacco use	
___ Whining	___ Sexual behavior	___ Headaches	
___ Compulsive behaviors	___ Rituals	___ Stomachaches	

Does your child/teen lose items (hats, coats, gloves, book bags, glasses) often? ☐ Yes ☐ No List: _____

Further History

Has your child or teen ever had problems with the following?

Item	Check Yes/No	Details	How Long?	Treated?
Physical abuse?	☐ Yes ☐ No	By whom? _____	_____	☐ Yes ☐ No
Sexual abuse?	☐ Yes ☐ No	By whom? _____	_____	☐ Yes ☐ No
Run away from home?	☐ Yes ☐ No	When? _____	_____	☐ Yes ☐ No
Arrested or adjudicated?	☐ Yes ☐ No	For what? _____	_____	☐ Yes ☐ No
Set a fire?	☐ Yes ☐ No	When/how? _____	_____	☐ Yes ☐ No
Assaulted someone?	☐ Yes ☐ No	Who? _____	_____	☐ Yes ☐ No
Destroyed property?	☐ Yes ☐ No	When? _____	_____	☐ Yes ☐ No

Hurt self?	☐ Yes ☐ No	When? _____	Severity: _____	☐ Yes ☐ No
Threatened to hurt self?	☐ Yes ☐ No	When? _____	How? _____ _____	☐ Yes ☐ No
Threatened to hurt someone?	☐ Yes ☐ No	When? _____	How? _____ _____	☐ Yes ☐ No
Used a weapon?	☐ Yes ☐ No	When? _____	What?_____	☐ Yes ☐ No
Used alcohol or drugs? List: _____	☐ Yes ☐ No	When? _____	How often? _____	☐ Yes ☐ No
Used tobacco?	☐ Yes ☐ No	When? _____	How often? _____	☐ Yes ☐ No
Grades drop in school a lot?	☐ Yes ☐ No	When? _____	How? _____	☐ Yes ☐ No
Used tutors/Ed Specialists	☐ Yes ☐ No	When? _____	Subjects: _____ _____	☐ Yes ☐ No
Sexually active?	☐ Yes ☐ No	When? _____	Partner age? _____	☐ Yes ☐ No
Cruelty to animals?	☐ Yes ☐ No	When? _____	How often? _____	☐ Yes ☐ No
Rituals, compulsive behaviors?	☐ Yes ☐ No	When? _____	How often? _____	☐ Yes ☐ No
Shyness or social problems?	☐ Yes ☐ No	What? _____	How often? _____	☐ Yes ☐ No

Mother: When you ask child/teen to do something what percent of time do they comply? _____ %

Father: When you ask child/teen to do something what percent of time do they comply? _____ %

Does your child teen ever warrant discipline? ☐ Yes ☐ No Situations: _____

Types of Discipline You Employ	**Avg. Times/Day**	**Avg. Length of Time**	**Child Response**
☐ Ignoring	_____	_____	_____
☐ Spanking	_____	_____	_____
☐ Yelling	_____	_____	_____
☐ Reward System	_____	_____	_____
☐ Lecturing	_____	_____	_____
☐ Time Outs	_____	_____	_____
☐ Natural Consequences	_____	_____	_____
☐ Nothing seems to work well	_____	_____	_____
☐ Other	_____	_____	_____

Any other comments about behavioral or emotional regulation issues?

_____

_____

_____

_____

_____

School History (Schools Attended - Please Include Pre-School and Grades Attended)

School Name	Years Attended	Grades	Comments
1. _____	_____to_____	_____to_____	_____
2. _____	_____to_____	_____to_____	_____
3. _____	_____to_____	_____to_____	_____
4. _____	_____to_____	_____to_____	_____
5. _____	_____to_____	_____to_____	_____
6. _____	_____to_____	_____to_____	_____

Has Your Child Been Classified With/As:

Reading Disability? ☐ Yes ☐ No If so, first month/year classified: ____/____

Speech Disability? ☐ Yes ☐ No If so, first month/year classified: ____/____

Language Disability? ☐ Yes ☐ No If so, first month/year classified: ____/____

Severe emotional disturbed? ☐ Yes ☐ No If so, first month/year classified: ____/____

Other health impaired? ☐ Yes ☐ No If so, first month/year classified: ____/____

Specific Health Problems: **A.D.H.D.** ☐ Yes ☐ No **Type 1 Diabetes** ☐ Yes ☐ No **Other**: ☐ Yes ☐ No List: _____

Is your child currently in special classes or resource room? ☐ Yes ☐ No

Is your child currently on an **Individualized Educational Plan (IEP)?** ☐ Yes ☐ No

Is your child currently on a **Section 504 Plan?** ☐ Yes ☐ No

If yes, which grades has your child been involved in special education services?

☐ Pre-K ☐ K ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

Does your child receive any accommodations at school? ☐ Yes ☐ No

If so, what are they? _____ _____ _____ _____ _____ _____

Has your child had individual psychological testing in school? ☐ Yes ☐ No If so, when? _____

Referred for: _____

Has your child been seen by a school counselor? ☐ Yes ☐ No If so, for: _____

Has your child repeated a grade? ☐ Yes ☐ No If so, which? _____

Has your child skipped a grade? ☐ Yes ☐ No If so, which? _____

Have your child's grades changed recently? ☐ Yes ☐ No If so, how? _____

What were your child's grades last term? _____

Does your child have any behavior problems at school? ☐ Yes ☐ No If so, list: _____

Does your child have problems getting along with other children? ☐ Yes ☐ No _____

How many minutes or hours does your child spend on daily homework? _____ Hours _____ Minutes

How long do you or another parent you spend with your child on daily homework? _____ Hours _____ Minutes

As a rule, does your child complete and hand in homework? ☐ Yes ☐ No

Often completes and hands in homework? ☐ Yes ☐ No

Often completes, but does not hand in? ☐ Yes ☐ No

Often neither completes nor hands in? ☐ Yes ☐ No

How difficult is it for your child/teen to start homework? ☐ Very Easy ☐ Easy ☐ Somewhat Hard ☐ Very Hard

How difficult is it for your child to complete homework? ☐ Very Easy ☐ Easy ☐ Somewhat Hard ☐ Very Hard

Any further comments or notes about homework, schoolwork, studying, or academic performance?

_____

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Family History

Do any of your FAMILY MEMBERS suffer from these problems? *(Consider family as brothers, sisters, parents, grandparents, aunts, uncles, cousins)*

Condition	**Mother's Family** (List relation)	**Father's Family** (List relation)
Learning Issues	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Depression	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Alcohol or Drug Problems (Specify):_____	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Mental Retardation	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Legal Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Hyperactivity	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Anxiety Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Perfectionism/OCD	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Perfectionism	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Language, Speech, or Hearing Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____

Tics or Nervous Habits	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Mood Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Behavior Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Anger Problems	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Psychiatric Hospitalization	Relation: _____ Relation: _____	Relation: _____ Relation: _____
Other (List): _____	Relation: _____ Relation: _____	Relation: _____ Relation: _____

Favored Activities or Entertainment

What are your child's favorite activities? _____

What do you like to do with your child? _____

What are your child's strong points? _____

What does your family do together? _____

How often do you read to your child? _____

How often does your child read alone? _____

What are your child's favorite books? _____

Hours your child watches TV on a typical weekday: ____ hours

Hours your child watches TV on a weekend day: ____ hours

Hours your child uses computers per day: ____ hours

Hours your child uses video games per day: ____ hours

Hours your child uses the Internet per day: ____ hours

Does your child have computer use problems? ☐ Yes ☐ No How often? _____

Does your child **like** to practice anything? ☐ Yes ☐ No Please list: _____

Does your child play a musical instrument? ☐ Yes ☐ No What instrument? _____

Exercise

Does your child get regular aerobic exercise? ☐ Yes ☐ No Hours per week: _____

Does your child play a sport regularly? ☐ Yes ☐ No Sports: _____

Does your child enjoy sports? ☐ Yes ☐ No

Friendship History

Does your child have a best friend? ☐ Yes ☐ No Friend's name: _____

Does your child play with a regular group of children at school? ☐ Yes ☐ No

Does your child play regularly with a group of children in your neighborhood? ☐ Yes ☐ No

Does your child show problems getting along with friends? ☐ Yes ☐ No

Does your child have trouble getting along with siblings? ☐ Yes ☐ No

Other friend, peers, or sibling issues? ☐ Yes ☐ No List: _____