

CHILD/YOUTH HISTORY FORM

Child's Name: _____ Age: _____ Birth Date: _____ Sex: *Male Female*

Person filling out this form: _____ Relationship: _____ Phone: _____

Who requested that your child be evaluated, and why? _____

Child's school: _____ Grade: _____ Teacher: _____

Special placement (if any): _____ Section 504: *Yes No* Special Ed: *Yes No*

Briefly state the reason for this visit: _____

CURRENT LIVING SITUATION:

Child is presently living with: *Natural Mother Stepmother Adoptive Mother Foster Mother Natural Father Stepfather
Adoptive Father Foster Father Grandparent(s) Aunt/Uncle Sibling Other* _____

How many people currently live in the household? _____ Does the child move between multiple households? *Yes No*

Please describe where each member of the household sleeps: _____

FAMILY HISTORY:

Is your child adopted? *Yes No* If so, please briefly describe the age of your child when adopted, from where the child was adopted, and the circumstances of the adoption: _____

Were any methods used to enhance fertility in this birth? If so, please describe: _____

BIOLOGIC MOTHER:

Name: _____ Age: _____ Highest grade completed: _____

Occupation: _____

Has the biologic mother or any of her relatives experienced any of the following psychological or emotional difficulties? *Please place a checkmark by the difficulty and then list the person who has or had the problem.*

- | | |
|--|---|
| <input type="checkbox"/> Anxiety disorders _____ | <input type="checkbox"/> OCD _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Bipolar Disorder _____ |
| <input type="checkbox"/> Suicide or suicide attempt(s) _____ | <input type="checkbox"/> Cutting/Self Injury _____ |
| <input type="checkbox"/> ADD/Attention difficulties _____ | <input type="checkbox"/> Learning disabilities _____ |
| <input type="checkbox"/> Aggressive or violent behaviors _____ | <input type="checkbox"/> Psychosis or severe thought problems _____ |
| <input type="checkbox"/> PTSD/Post Traumatic Stress Disorder _____ | <input type="checkbox"/> Physical or sexual abuse _____ |
| <input type="checkbox"/> Alcohol abuse _____ | <input type="checkbox"/> Other substance abuse _____ |
| <input type="checkbox"/> Social difficulties _____ | <input type="checkbox"/> Legal trouble _____ |
| <input type="checkbox"/> Severe trauma _____ | <input type="checkbox"/> Other _____ |

Do any medical illnesses run in the biologic mother's family (i.e., thyroid, diabetes, seizures, movement disorders such as tics or other neurological problems, allergies, etc.)? _____

BIOLOGIC FATHER:

Name: _____ Age: _____ Highest grade completed: _____

Occupation: _____

Has the biologic father or any of his relatives experienced any of the following psychological or emotional difficulties? Please place a checkmark by the difficulty and then list the person who has or had the problem.

- Anxiety disorders _____
- Depression _____
- Suicide or suicide attempt(s) _____
- ADD/Attention difficulties _____
- Aggressive or violent behaviors _____
- PTSD/Post Traumatic Stress Disorder _____
- Alcohol abuse _____
- Social difficulties _____
- Severe trauma _____
- OCD _____
- Bipolar Disorder _____
- Cutting/Self Injury _____
- Learning disabilities _____
- Psychosis or severe thought problems _____
- Physical or sexual abuse _____
- Other substance abuse _____
- Legal trouble _____
- Other _____

Do any medical illnesses run in the biologic father's family (i.e., thyroid, diabetes, seizures, movement disorders such as tics or other neurological problems, allergies, etc.)? _____

PARENTS:

How long have the child's parents been: Married: _____ Separated: _____ Divorced: _____ Living together: _____

If the parents are separated or divorced, please describe custody (physical and legal) and visitation rights. _____

If married, describe current relationship (i.e., supportive, respectful, conflicted, continuous fighting, unpredictable, etc.): _____

Please list any previous marriages: _____

Are there currently any significant marital stressors? Yes No If so, please briefly explain: _____

SIBLINGS:

Name	Age	Quality of Relationship	Living at home?	
			Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No
_____	_____	_____	Yes	No

Have any of the siblings experienced psychological or emotional problems (suicide or suicide attempts, attention or learning difficulties, legal problems, alcohol or substance abuse, social difficulties, or medical problems)? If so, please state who and the nature of the problem.

Are there any other relatives or persons living in the home? _____

Please list (current or past) significant areas of conflict in the home between your child and others. _____

BIRTH HISTORY:

Mother's age at time of birth: _____ **Father's age at time of birth:** _____

Did the mother smoke during the pregnancy? Yes No **If so, how many cigarettes per day?:** _____

Was alcohol consumed during pregnancy? Yes No **If so, what was the amount per day?** _____

Were any drugs used during the pregnancy? Yes No **If so, list the name of the drug and the amount:** _____

Was the delivery unusual in any way? Yes No **If yes, please explain:** _____

Did you have a cesarean? Yes No **If yes, please describe complications:** _____

Please add any comments regarding your pregnancy or delivery that might be significant: _____

INFANCY PERIOD:

Did either parent have problems with depression after the birth? Yes No

If yes, please briefly describe: _____

Did either parent have significant problems adjusting after the birth? Yes No

If yes, please briefly describe: _____

Describe any physical or emotional separations from the caregivers in the first few years of life: _____

Was your child: Breast fed Bottle fed

DEVELOPMENTAL HISTORY:

Motor development (sitting, crawling, walking): Average Early Late

Speech and language: Average Early Late

Self-help skills (dressing, brushing, hygiene, etc.): Average Early Late

Bowel trained: _____ Average Early Late

Bladder trained: _____ Average Early Late

Started to read: _____ Average Early Late

COORDINATION:

Handedness Left Right Both

Please rate your child on the following skills:

Handwriting: Neat Messy Illegible

Fine motor skills: Gifted Average Poor

Hand/Eye coordination: Gifted Average Poor

Athletic abilities: Gifted Average Poor Last chosen for teams

Does your child have an excessive number of accidents compared to other children? Yes No *Uncertain*

If yes, please describe: _____

BEHAVIORS, MOODS, AND ATTITUDES:

Check all that apply:

- | | | | |
|------------------------------------|--|---|---|
| <input type="checkbox"/> adaptable | <input type="checkbox"/> rocking | <input type="checkbox"/> able to play alone | <input type="checkbox"/> difficulty with attention |
| <input type="checkbox"/> impulsive | <input type="checkbox"/> easy to manage | <input type="checkbox"/> underactive/passive | <input type="checkbox"/> deals well with frustration |
| <input type="checkbox"/> stubborn | <input type="checkbox"/> dare-devil | <input type="checkbox"/> eating difficulties | <input type="checkbox"/> difficulty with changes |
| <input type="checkbox"/> cautious | <input type="checkbox"/> shy or timid | <input type="checkbox"/> sleeping difficulties | <input type="checkbox"/> responds well to challenges |
| <input type="checkbox"/> moody | <input type="checkbox"/> easily frustrated | <input type="checkbox"/> aggressive/violent | <input type="checkbox"/> obsessive or compulsive |
| <input type="checkbox"/> sensitive | <input type="checkbox"/> empathic | <input type="checkbox"/> wants to be left alone | <input type="checkbox"/> prefers things over people |
| <input type="checkbox"/> playful | <input type="checkbox"/> severe tantrums | <input type="checkbox"/> slow to warm up | <input type="checkbox"/> overwhelmed by challenges |
| <input type="checkbox"/> fearful | <input type="checkbox"/> curious | <input type="checkbox"/> temper outbursts | <input type="checkbox"/> overactive/into everything |
| <input type="checkbox"/> angry | <input type="checkbox"/> staring spells | <input type="checkbox"/> breath holding spells | <input type="checkbox"/> difficulty interacting with others |
| <input type="checkbox"/> happy | <input type="checkbox"/> affectionate | <input type="checkbox"/> head banging | <input type="checkbox"/> stuttering/speech problems |
| <input type="checkbox"/> sad | <input type="checkbox"/> irritable | <input type="checkbox"/> easily engages others | |

Were any of the following present, to a significant degree, during the first year of life? *If so, please describe:*

- Did not enjoy cuddling: _____
- Was not calmed by being held: _____
- Was difficult to comfort: _____
- Was colicky: _____
- Was excessively restless: _____
- Was excessively irritable: _____
- Experienced sleep difficulties: _____
- Experienced difficulty with nursing or food: _____

How would you describe your child's conscience? Normal Lax Harsh Preoccupied with certain issues

Do you have any concerns about your child's self esteem? Yes No *If yes, please describe:* _____

Do you have any concerns with regard to your child's sexual knowledge or awareness? Yes No

Gender identity? Yes No Sexual orientation? Yes No *If yes, please describe:* _____

Please check any of the following that this child has problems with (currently or in the past):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> bed wetting | <input type="checkbox"/> depression/ withdrawn | <input type="checkbox"/> obsessive-compulsive behaviors | <input type="checkbox"/> anxiety/panic |
| <input type="checkbox"/> soiling | <input type="checkbox"/> significant weight change | <input type="checkbox"/> self-conscious, embarrassed | <input type="checkbox"/> shy |
| <input type="checkbox"/> sleep problems | <input type="checkbox"/> oppositional/ defiant | <input type="checkbox"/> irritability, anger | <input type="checkbox"/> fighting |
| <input type="checkbox"/> lying | <input type="checkbox"/> setting fires | <input type="checkbox"/> cruelty to animals | <input type="checkbox"/> stealing |
| <input type="checkbox"/> eating problems | <input type="checkbox"/> secretiveness | <input type="checkbox"/> crying episodes | <input type="checkbox"/> immaturity |
| <input type="checkbox"/> sexual problems | <input type="checkbox"/> extreme moodiness | <input type="checkbox"/> bullied by others | <input type="checkbox"/> bully |
| <input type="checkbox"/> poor motivation | <input type="checkbox"/> change in personality | <input type="checkbox"/> suspicious, distrustful | <input type="checkbox"/> hallucinations |
| <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> other substance abuse | <input type="checkbox"/> strange ideas or behaviors | <input type="checkbox"/> impulsiveness |
| <input type="checkbox"/> explosive episodes | <input type="checkbox"/> property destruction | <input type="checkbox"/> self-destructive behaviors | <input type="checkbox"/> running away |
| <input type="checkbox"/> aggression/violence | <input type="checkbox"/> frequent accidents | <input type="checkbox"/> suicidal talk or behaviors | <input type="checkbox"/> guilt |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> bad group of friends | <input type="checkbox"/> Other _____ | |

Please list the types of discipline you have tried with your child and its effectiveness: _____

Please check any of the following significant events that have occurred within your family and briefly describe:

- death of a family member or significant person: _____
- significant moves: _____
- trauma: _____
- divorce/separations: _____
- serious illness of a family member: _____
- parental unemployment: _____
- financial stress: _____
- trouble with the law: _____
- other: _____

Please express any additional concerns regarding your child: _____

Please list your child's strengths (i.e., academic, athletic, personality, creativity, funny, etc.): _____

Does your child have an important pet in their life? If so, please explain. _____

COMPREHENSION AND UNDERSTANDING:

Do you believe your child is able to understand directions and situations as well as other children his/her age? Yes No

If not, please explain: _____

If your child tells a story about a show, event, etc., do you or others have difficulty understanding him/her? Yes No

If yes, is it because he/she (check all that apply):

- appears confused
- is disorganized
- leaves out important information
- loses train of thought
- has trouble finding the right words
- has trouble engaging others

Does your child have trouble remembering things that he/she really cares about? Yes No

Please describe: _____

Does your child have difficulty following routines (bedtime, dressing, etc.)? Yes No

Please describe: _____

Does your child frequently lose things or have trouble being organized? Yes No

Please describe: _____

How would you rate your child's overall level of intelligence compared to other children?

- Gifted
- Above Average
- Average
- Below average
- Extremely low

How would your child rate his/her intelligence compared to other children?

- Gifted
- Above Average
- Average
- Below average
- Extremely low

INDEPENDENT ACTIVITIES:

Please describe your child's ability to function in an independent manner: _____

SCHOOL HISTORY:

Did your child attend daycare or preschool? Yes No *If yes, please estimate approximately how many hours per week: _____*
What are your current care arrangements for this child before and after school? _____

Beginning with kindergarten, please list schools and indicate performance:

Grade	School	Academic Performance			Behavioral Performance		
KG	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
1 st	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
2nd	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
3rd	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
4th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
5 th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
6th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
7th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
8th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
9th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
10 th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
11 th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
12 th	_____	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor

Are there any known learning disabilities? Yes No

If yes, please list: _____

Are any of the following unusually difficult for your child, compared to other kids?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> reading quietly | <input type="checkbox"/> reading out loud | <input type="checkbox"/> sounding out unknown words | <input type="checkbox"/> taking tests |
| <input type="checkbox"/> learning basic math skills | <input type="checkbox"/> showing work | <input type="checkbox"/> algebra | <input type="checkbox"/> geometry |
| <input type="checkbox"/> writing in cursive | <input type="checkbox"/> spelling | <input type="checkbox"/> grammar | <input type="checkbox"/> getting started writing |
| <input type="checkbox"/> taking notes | <input type="checkbox"/> copying from the board | <input type="checkbox"/> remembering to do homework | <input type="checkbox"/> turning in homework |

Has your child been in any special programs such as speech, reading, occupational therapy, etc? Yes No

If yes, please explain and list grades: _____

Has your child ever had to repeat a grade? Yes No

If yes, please explain: _____

CURRENT ACADEMIC PERFORMANCE:

Your child's current performance at school is:

- Excellent Good Satisfactory Unsatisfactory Failing

Does your child enjoy school? Yes No Did your child enjoy a previous school more: Yes No

School subject strengths: _____

School subject weaknesses: _____

Check any of the following problems your child has with school:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> problems with written language | <input type="checkbox"/> poor handwriting | <input type="checkbox"/> poor at spelling | <input type="checkbox"/> poor reader |
| <input type="checkbox"/> does not remain seated | <input type="checkbox"/> frequently sent out of class | <input type="checkbox"/> too withdrawn or passive | <input type="checkbox"/> impulsive |
| <input type="checkbox"/> forgets instructions | <input type="checkbox"/> interferes with other's tasks | <input type="checkbox"/> difficulty being quiet | <input type="checkbox"/> poor at math |
| <input type="checkbox"/> requires additional supervision | <input type="checkbox"/> talks inappropriately | <input type="checkbox"/> makes careless mistakes | <input type="checkbox"/> daydreams |
| <input type="checkbox"/> messy and disorganized | <input type="checkbox"/> non-compliant in class | <input type="checkbox"/> oppositional with teachers | <input type="checkbox"/> skips school |
| <input type="checkbox"/> does not complete classroom work | <input type="checkbox"/> fails to check homework | <input type="checkbox"/> difficulties in groups | <input type="checkbox"/> bullied |
| <input type="checkbox"/> excessive time to complete assignments | <input type="checkbox"/> difficulties with peers | <input type="checkbox"/> not interested in friends | <input type="checkbox"/> socially immature |
| <input type="checkbox"/> poor attention span | <input type="checkbox"/> doesn't think he/she is smart | <input type="checkbox"/> low frustration tolerance | <input type="checkbox"/> hates PE/gym |
| <input type="checkbox"/> does not do homework | <input type="checkbox"/> testing anxiety | <input type="checkbox"/> mind goes blank during tests | |

Please check all pro-social extracurricular activities that your child is involved in:

- | | | | | |
|---------------------------------------|--|--|---|---|
| <input type="checkbox"/> athletics | <input type="checkbox"/> music | <input type="checkbox"/> theater | <input type="checkbox"/> dance | <input type="checkbox"/> volunteering/community service |
| <input type="checkbox"/> school clubs | <input type="checkbox"/> computer groups | <input type="checkbox"/> debate | <input type="checkbox"/> citizenship/government | <input type="checkbox"/> business/ Junior Achievement |
| <input type="checkbox"/> martial arts | <input type="checkbox"/> part-time job | <input type="checkbox"/> caring for siblings | | <input type="checkbox"/> other |

PEER RELATIONSHIPS:

Does your child seek friendships with peers? Yes No

Is your child sought by peers for friendship? Yes No

Check any of the following which describes your child's interactions with peers?:

- | | | |
|---|--|---|
| <input type="checkbox"/> plays well in groups | <input type="checkbox"/> teased by other kids | <input type="checkbox"/> no problems |
| <input type="checkbox"/> cooperative | <input type="checkbox"/> supportive | <input type="checkbox"/> shares well |
| <input type="checkbox"/> plays primarily with younger kids | <input type="checkbox"/> plays primarily with older kids | <input type="checkbox"/> afraid other kids do not like them |
| <input type="checkbox"/> trouble making friends | <input type="checkbox"/> loses friends | <input type="checkbox"/> no friends |
| <input type="checkbox"/> few friends | <input type="checkbox"/> rejected by other kids | <input type="checkbox"/> leader |
| <input type="checkbox"/> easily led by others | <input type="checkbox"/> aggressive or mean | <input type="checkbox"/> frequent arguments |
| <input type="checkbox"/> frequent fights | <input type="checkbox"/> bossy and controlling | <input type="checkbox"/> teasing |
| <input type="checkbox"/> jealous | <input type="checkbox"/> bragging/boastful | <input type="checkbox"/> uncooperative |
| <input type="checkbox"/> feelings get hurt easily | <input type="checkbox"/> risky or dangerous behavior | <input type="checkbox"/> involved in delinquent behavior |
| <input type="checkbox"/> involved in alcohol or substance abuse | | |

Please add any additional comments regarding school functioning: _____

CHILD'S MEDICAL HISTORY:

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

- | | |
|---|---|
| <input type="checkbox"/> hospitalizations _____ | <input type="checkbox"/> operations _____ |
| <input type="checkbox"/> handicaps or deformities _____ | <input type="checkbox"/> failure to grow _____ |
| <input type="checkbox"/> pneumonia _____ | <input type="checkbox"/> asthma _____ |
| <input type="checkbox"/> allergies _____ | <input type="checkbox"/> diabetes _____ |
| <input type="checkbox"/> skin problems _____ | <input type="checkbox"/> multiple ear infections _____ |
| <input type="checkbox"/> tubes placed _____ | <input type="checkbox"/> seizures _____ |
| <input type="checkbox"/> persistent high fevers _____ | <input type="checkbox"/> obesity _____ |
| <input type="checkbox"/> tics or repetitive movements _____ | <input type="checkbox"/> head injury; loss of consciousness _____ |
| <input type="checkbox"/> other physical trauma _____ | <input type="checkbox"/> coma _____ |
| <input type="checkbox"/> encephalitis _____ | <input type="checkbox"/> eye problems _____ |
| <input type="checkbox"/> hearing problems _____ | <input type="checkbox"/> anemia _____ |
| <input type="checkbox"/> stomach problems _____ | <input type="checkbox"/> constipation _____ |
| <input type="checkbox"/> poisoning _____ | <input type="checkbox"/> other _____ |

Has your child ever had a neurologic evaluation (neuro exam, MRI, CAT Scan, EEG, etc.)? Yes No

If so, please describe: _____

Has your child's vision been tested? Yes No Normal Date: _____

His your child's hearing been tested? Yes No Normal Date: _____

Please list all medications that your child has taken for longer than one month. If possible, please describe your child's response to the medications as well as notable side effects. If additional space is needed for comments, please continue on reverse side.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

CHILD'S PRESENT MEDICAL STATUS:

Height: _____ Weight: _____ Medical Doctor/pediatrician: _____

List any present illness(es) for which your child is being treated: _____

When was your child's last physical exam? _____ Was blood work done? _____

Describe your child's appetite and diet: _____

List all medications your child is currently taking for medical problems:

<u>Problem</u>	<u>Medication</u>	<u>Dose</u>	<u>Date started</u>	<u>Response</u>	<u>Side effects</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have there been any allergic reactions to medications? Yes No *If so, please describe:* _____

How does your child sleep at night? _____

Does your child frequently complain of: *Please check all that apply*

- headaches
- stomachaches
- painful urination
- menstrual problems
- dizziness
- staring into space
- chest pain
- skin problems
- sleep problems
- tiredness
- trouble with vision
- heart palpitations
- nightmares
- difficulty breathing
- trouble hearing

Who is/are your child's current medical doctor(s)? _____

What is the nature of your child's relationship with their doctor? _____

May I contact him/her if needed? Yes No

FREE TIME:

Please describe how your child generally spends her/his free time:

- plays alone
- plays video games alone
- listening to/playing music
- plays with friends
- plays video games with friends
- texting/talking with friends
- plays sports
- reads
- skateboard
- watches TV
- draws/art projects
- bicycle
- internet
- builds things
- other: _____

Please list the approximate number of hours per day that your child watches TV and list the type(s) of shows watched: _____

Please list the approximate number of hours per day that your child plays video games and list the type(s) of games played: _____

PREVIOUS MENTAL HEALTH TREATMENT

Has your child ever received any type of psychiatric, psychological, or academic evaluation or treatment? Yes No

If so, please fill in the following:

Person or institution	Date	Address	Telephone
-----	-----	-----	-----
-----	-----	-----	-----
-----	-----	-----	-----

Has your child ever taken psychiatric medications? Yes No

If yes, please list:

Problem	Medication	Dose	Date Started	Response	Side Effects
-----	-----	-----	-----	-----	-----
-----	-----	-----	-----	-----	-----
-----	-----	-----	-----	-----	-----

Have you been satisfied with previous mental health care (if applicable)? _____

CURRENT/PREVIOUS NATURAL TREATMENTS:

Please list any vitamins, remedies, or holistic treatments you use with your child. _____

SPIRITUAL ORIENTATION:

Please list your family's spiritual orientation or religion: _____
 How active are these beliefs in your life? Very active Somewhat active Not very active
 If you like, share some of your thoughts on your spiritual practice/religion: _____

IN CONCLUSION:

Please make any additional comments you wish with regard to your child: _____

Thank you for your patience and hard work in completing this form. It will help in my work with you.