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FAMILY INFORMATION FORM

IDENTIFYING INFORMATION

Child's Name: _____ Date Completed: _____

Ethnicity/race: _____ DOB: _____

Gender: _____ Primary language if other than English: _____

Person answering questions: _____ Relationship: _____

Person who assisted in completing this form: _____

PARENT/GUARDIAN INFORMATION/CHILD CUSTODY AND PLACEMENT HISTORY

Who has current custody/guardianship of child? ☐ mother ☐ father ☐ both parents ☐ DSHS

☐ relative: _____ ☐ other: _____

If the Legal Guardian is someone other than the parents complete the following:

Name: _____

Address: _____

Phone: _____

Relationship to child: _____

Comment on history/potential for changes in custody: _____

_____

Caregiver 1 Information:

Relationship to child: ☐ biological ☐ adoptive ☐ foster ☐ step ☐ other_____

Name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Years of Education/Degree: _____

General Health: _____

Caregiver 2 Information:

Relationship to child: ☐ biological ☐ adoptive ☐ foster ☐ step ☐ other_____

Name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: _____ Years of Education/Degree: _____

General Health: _____

Step Mother's Name (if applicable): _____

Step Father's Name (if applicable): _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

With whom is this child currently living (list ALL members of household):

Name	Gender	Age	Relationship

Please indicate the type of living situation in which the child resides: ☐ family home ☐ non-parent relative caregiver ☐ foster home ☐ group home ☐ other: _____

Has family had multiple moves (3+) in the past 12 months? ☐ Yes ☐ No

Has family experienced homelessness in the past 12 months? ☐ Yes ☐ No

OUT-OF-HOME PLACEMENT HISTORY (IF APPLICABLE)

Has the child ever been separated from their parents/primary caregivers for any significant periods of time?

☐ Yes ☐ No

How many out-of-home placements has the child had in the past 12 months? _____

Provide information about the child's age, circumstances of the separation, and child's response: _____

How did the move(s) effect the child: _____

Is the child currently at risk for out-of-home placement? ☐ Yes ☐ No If yes, why: _____

REASONS FOR EVALUATION

Who referred you: _____

Please state your concerns; specify nature of problem, onset, duration, frequency, and severity: _____

Did a specific event lead to this request for evaluation/treatment? ☐ Yes ☐ No. If so, please describe:

What do you hope to get from this evaluation/treatment? _____

_____

_____

_____

BIRTH AND EARLY INFANCY HISTORY

This information should be provided as it relates to the biological parents of the child, if known.

Was the pregnancy planned? ☐ Yes ☐ No

Any difficulty becoming pregnant? If so, please explain: _____

Was the mother exposed to any of the following: ☐ None

TYPE	LIST SPECIFIC SUBSTANCES	AMOUNT	MONTH OF PREGNANCY
DRUGS			
ALCOHOL			
TOBACCO			
MEDICATIONS			
X-RAYS			

Did the mother experience any of the following during pregnancy? ☐ None

	DESCRIBE THE PROBLEM	MONTH OF PREGNANCY
FEVER		
FLU		
SKIN RASH		
SPOTTING/BLEEDING		
KIDNEY INFECTIONS		
VAGINAL INFECTIONS		
SWELLING OF HANDS/FEET/FACE		
HIGH BLOOD PRESSURE		
DIZZY SPELLS		
CONVULSIONS		
HEADACHES		
BLURRED VISION		
VOMITING		
OTHER ILLNESSES		

Length of pregnancy: _____ Age of mother: _____ Weight gain: _____

Describe labor and/or delivery with this child: ☐ Easy, no problems ☐ Difficult (please explain below)

☐ Natural (vaginal) ☐ C-section ☐ Forceps Please explain: _____

_____

Did the baby cry immediately after birth? ☐ Yes ☐ No Apgar scores (if known): _____

Birth statistics: Weight: _____ Length: _____ Head circumference: _____

How soon after the birth did the mother see the baby? _____ Hold the baby? _____

Hospital where the child was born: _____

Duration of mother's hospital stay: _____ Baby's hospital stay: _____

Were there any problems noted by anyone while the baby was still in the hospital? (For example, prolonged jaundice, need for incubator/oxygen, infections, feeding problems, convulsions): _____

Were there any difficulties during the baby's first month of life? (excessive crying, health problems, etc.): _____

Was the infant ☐ bottle or ☐ breast fed ? Number of months breast fed: _____

Were there any difficulties with feeding (e.g. recurrent vomiting, "colic", poor suck, low weight gain)?

Did parents have trouble adjusting to the new baby? _____

DEVELOPMENTAL HISTORY

Any concerns about the child's development? ☐ Yes ☐ No.

Was development perceived as being ☐ average? ☐ below average? ☐ above average?

Please identify your child's developmental progress in the following areas:

Areas of Development	***Compare your child's development to other children his/her age (please put an X in the box below):***			***Please comment on areas of strength and needs in your child's development:***
	About the same	Slower	Faster	Please note any delay/ deterioration/ loss of skills
Gross Motor Skills (running, throwing ball, bicycling)				
Fine Motor Skills (coloring, drawing, writing, scissors use)				
Speech & Language Skills (pronunciation, vocabulary)				
Social Skills (sharing, cooperating, taking turns)				
Self-Control Skills (impulse control, delaying gratification)				
Self-Concept (child's opinion of self, abilities, worth)				
Cognitive Skills (memory, comprehension, knowledge)				

Has your child had any formal developmental testing? ☐ Yes ☐ No If yes, please provide details: _____

Has your child received any early intervention services? o Yes o No If yes, please provide details about the services and provider(s): _____

Can your child perform the following tasks without help: (check if yes)

- ☐ eat using a spoon and fork? _____
- ☐ cut meat/food with a knife? _____
- ☐ drink from a glass? _____
- ☐ undress? _____
- ☐ dress alone? _____
- ☐ tie shoelaces? _____
- ☐ toilet him/herself? _____
- ☐ bathe him/herself? _____

CHILD'S MEDICAL/PHYSICAL HISTORY

Who is the child's primary doctor? _____ Phone #: _____

Address: _____

Who is the child's primary dentist? _____ Phone #: _____

Address: _____

When was your child last seen by a physician? _____

For what reason? _____

Date and results of last physical examination: _____

Child's current height: _____ weight: _____ Is the child's general physical health good? ☐ Yes ☐ No

Serious and/or chronic illness now (or in past)? _____

Sleep problems (too much/too little)? _____

Are immunizations up to date? ☐ Yes ☐ No

Does the child have any of the following impairments/conditions (documented)? ☐ None reported

☐ Unknown ☐ developmental disability ☐ visual disability ☐ Deaf ☐ Hard of hearing

☐ medically compromised ☐ medical/physical disability ☐ neurological disability ☐ FAS/FAE

☐ Chronic medical/neurological condition which affects psychological functioning ☐ Other: _____

Has child had any history of seizures or head injury ☐ Yes ☐ No (if yes, specify type, duration, frequency and date of last EEG)? _____

_____

Has the child had any serious injuries/accidents or episodes with loss of consciousness? ☐ Yes ☐ No

If yes, please provide details: _____

History of medical hospitalizations and/or surgeries: ☐ None reported ☐ Unknown

Provider Name(s):	Dates/duration:	Conditions treated:	Complications:	Discharge status:

Current ongoing use of non-psychotropic medications for physical health: ☐ None reported ☐ Unknown

Name of medication(s):	Condition(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

Homeopathic, naturopathic, herbal and/or other alternative medicine treatments for physical health:

☐ None reported ☐ Unknown

Current	Past	Name of treatment:	Condition(s):	Prescribing MD:	Response/side effects:

Has your child had any of the following (please give details):

☐ recurrent headaches _____

☐ recurrent stomach aches _____

☐ recurrent diarrhea _____

☐ recurrent vomiting _____

☐ constipation _____

☐ vision problems _____

☐ hearing problems _____

☐ ear infections _____

☐ recurrent respiratory infections (bronchitis/bronchiolitis or pneumonia) _____

☐ allergies _____

☐ wheezing or asthma _____

- ☐ bladder problems _____
- ☐ problems with urination _____
- ☐ weight loss or gain _____
- ☐ skin problems _____
- ☐ problems with bones, muscles or joints _____
- ☐ tremor, shakes or jitters _____
- ☐ tics or other movement problems _____
- ☐ wets bed or him/herself _____
- ☐ soils bed or him/herself _____
- ☐ other _____

Does your child have any pain issues or concerns? ☐ Yes ☐ No If yes, explain: _____

_____

_____

Sexual Development (menstruation history, sexual activity, use of contraception, pregnancy history):_____

_____

Sexual orientation: _____

Gender: _____

Has patient experienced harassment or intolerance due to sexual orientation or gender? ☐ Yes ☐ No

Comments: _____

_____

Is child a teen parent? ☐ Yes ☐ No Details: _____

_____

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following conditions?

Check all that apply, past or present:

Condition/Circumstance	Child	Parent 1 ( )	Parent 2 ( )	Sibling	Parent 1's Family	Parent 2's Family
Mental Retardation						
Learning Disorder						
Attention Deficit						
Hyperactivity						
Epilepsy						
Neurological Disorders						
Alcohol Abuse						
Drug Abuse						
Physical/Emotional Abuse						
Sexual Abuse						
Depression						
Suicide Attempts						
Anxiety Disorders						
Specific Fears or Phobias						
Panic Attacks						
Schizophrenia						
Visual Disability/Problems						
Deaf/Hard of Hearing						
Tics/Tourette's Syndrome						
Chronic Illnesses						
Juvenile Delinquency						
Arrests/Incarceration						
Harassment by peers						
Homelessness						
Teen pregnancy						
School suspension/expulsion						
Special Education						
Birth Defects						
Miscarriages						
Other:_____						

CHILD SOCIAL-BEHAVIORAL AND PSYCHIATRIC HISTORY

How is your child's overall emotional health? _____

List all past outpatient psychiatric/psychological/mental health services: ☐ None reported ☐ Unknown

Provider Name(s):	Dates of tx:	Services provided:	Outcomes:	Termination reason(s):

List any history of psychiatric hospitalization and/or residential treatment: ☐ None reported ☐ Unknown

Provider Name(s):	Dates of tx:	Services provided:	Outcomes:	Discharge status:

Psychotropic medication history for behavioral health: ☐ None reported ☐ Unknown

Current	Past	Name of medication(s):	Condition(s):	Prescribing MD:	Dose/schedule:	Response/side effects:

Please list all other persons or agencies who have evaluated your child in the past:

Type of service	Service provider/address	Results	Dates

Does your child have behavior problems at home? (please specify): _____

Does your child have behavior problems at school? (please specify): _____

Does your child have behavior problems in the community (e.g. grocery store, daycare, public places, etc)? (please specify): _____

Does the child have any past/ current substance use/abuse? ☐ cigarettes ☐ drugs ☐ alcohol ☐ drugs/alcohol ☐ denies use ☐ remission 90+ days ☐ none If yes, please describe substances used, amount, and effect on child's performance at home and school: _____

Has the child engaged in any law breaking behavior? o Yes o No (Provide details about history of arrest, detention, gang involvement, diversion, etc.): _____

Has the patient had any history of the following emotional/behavioral problems:

☐ specific phobias: _____

☐ firesetting: _____

☐ animal mistreatment: _____

☐ enuresis/encopresis: _____

☐ self-injurious behaviors: _____

☐ other: _____

History of violence/grief and loss:

Has child been exposed to domestic violence? ☐ Yes ☐ No

Has child been a witness to violence or traumatic death? ☐ Yes ☐ No

Has child experienced death of parent/psychological parent? ☐ Yes ☐ No

Child abuse/neglect history:

Has child had history of ☐ physical abuse ☐ sexual abuse ☐ persistent inadequate parenting or neglect?

Has abuse/neglect been documented by CPS/Legal System? ☐ Yes ☐ No _____

Has the abuse history been previously addressed by a professional? ☐ Yes ☐No If so, how? _____

Please describe forms of discipline which have been used in the home and their effectiveness: _____

_____

_____

_____

Please make a brief statement about the relationship between patient and:

Parent 1 (_____): _____

Parent 2 (_____): _____

Siblings: _____

The closest relationship is between the patient and _____

The most troubled relationship is between the patient and _____

How has the patient's problem affected each family member:

Parent 1(_____):_____

Parent 2(_____): _____

Siblings: _____

Were patient's parents 18 years of age or less at time of child's birth? ☐ Yes ☐ No

Are there attachment difficulties with a history of disrupted parenting before age 5? ☐ Yes ☐ No

_____

_____

Describe sleeping arrangements in the family: _____

_____

Does your child participate in any community activities (e.g. sports, boys & girls, church)? o Yes o No

If yes, please list the activities/groups: _____

_____

Does your child have hobbies, interests, etc? _____

_____

What games/activities does your child prefer? _____

_____

Are chores routinely assigned to your child? ☐ Yes ☐ No If yes, which ones? _____

_____

Does your child have as many friends as most other children their age? ☐ Yes ☐ No Does

your child have friends come over and play at your house? ☐ Yes ☐ No

Does your child play at the houses of their friends? ☐ Yes ☐ No

Has your child had any friends stay overnight at your house, or have they stayed overnight at another friend's house? ☐ Yes ☐ No ☐ not age appropriate

Has child been persistently harassed or abused by peers? ☐ Yes ☐ No

Please list those qualities about your child that you consider to be strong positive points. _____

_____

_____

Please list those qualities about your child that you consider to be strong negative points. _____

_____

_____

SCHOOL/VOCATIONAL HISTORY

Is the patient currently enrolled in school? o Yes o No

Current school placement:

School District: _____ Grade: _____

School Name: _____ Phone #: _____

Teacher/Counselor/IEP Coordinator: _____

Is child enrolled in special education? ☐ Yes ☐ No Current IEP? ☐ Yes ☐ No (if yes, request copy)

Child is designated: ☐ Seriously behaviorally disordered ☐ Learning disordered ☐ Health impaired

Child's classroom is: ☐ Regular Education ☐ Regular Education with pull-out to Resource Room

☐ Self- contained classroom ☐ Generic special education classroom

☐ Inclusion in regular education (_____ hours/day) ☐ Other: _____

Describe current daily functioning in school setting (including strengths and needs): _____

_____

_____

_____

Review history of school placements and functioning: (including learning/behavior problems, multiple school placements, past educational testing, estimated level of achievement): _____

_____

_____

Has the child been suspended/expelled in past 12 months? ☐ Yes ☐ No How many times? _____

What school interventions have been used to address problems: ☐ None ☐ Special seating arrangement

☐ Tutoring ☐ Token economy ☐ Groups ☐ Classroom aide ☐ Parent(s) called ☐ other:_____

Vocational Assessment for Youth: ☐ Not applicable

Has youth had any paid employment? ☐ Yes ☐ No If yes, provide details of employment history: _____

_____

Has youth had any significant volunteer experiences? ☐ Yes ☐ No If yes, provide details of experiences: _____

_____

FAMILY HISTORY

Do you have any family members in the area that you can rely on for help? ☐ Yes ☐ No

Do you have any friends in the area that you can rely on for help? ☐ Yes ☐ No

Do you have any other adults in the area that you can rely on for help? ☐ Yes ☐ No

Does your family have any identified religion or spiritual beliefs and practices? ☐ Yes ☐ No

Please describe activities that your family likes to do together:

Are there currently any unusual stresses your family is experiencing?

Is there any family conflict currently in the household in which the child resides ☐ Yes ☐ No

Is family experiencing significant family discord between 2 or more individuals? ☐ Yes ☐ No

Does patient have a troubled sibling? ☐Yes ☐ No

If yes to any of the above, please provide details and effect on child:

Brief statement about parents'/caregivers' own relationship:

Has there been any domestic violence in the household in which the child resides? ☐ Yes ☐ No

If yes, please provide details and effect on child:

Does the parent/caregiver have a history of substance abuse which disrupts their capacity to parent?

☐ Yes ☐ No (If yes, provide details about type of substances, use patterns, treatment history, etc.)

Has parent/caregiver been involved in the criminal justice system? ☐ Yes ☐ No

If yes, provide details about arrests, periods of incarceration, restraining orders, outstanding legal issues, etc.

Is your current housing adequate to meet your family needs? ☐ Yes ☐ No

Please provide details on the housing and how it does/does not meet your family needs: _____

Please indicate any agencies currently involved with your child and/or family:

☐ Family Reconciliation Svcs (FRS) ☐ Child Protective Svcs (CPS) ☐ At-risk youth petition (ARY)

☐ Developmental Disabilities (DDD) ☐ Juvenile Court/probation ☐ Substance abuse counseling

Details: _____

HEALTH BELIEFS/CULTURAL ASSESSMENT

Ethnic/cultural identification of parent/child/extended family (including language spoken at home): _____

Immigration history (country of origin, immigration process, length of time in U.S., acculturation/ethnic identity): _____

Religious/spiritual practices of patient/caregivers/family: _____

Culturally/socially relevant beliefs regarding mental health and illness (include beliefs and attributions regarding current problem, general beliefs about illness, health, models of pathology, and treatment): _____

Is there anything else you would like us to know about this child that we did not ask? _____