Center for Biofeedback and Behavior Therapy, LLC

15028 Beltway Dr. • Addison, TX 75001 • Local: (469) 358-1309 • Fax: (972) 386-6700 • www.onlinebiofeedback.com

Child/Adolescent Background Information *(use for all minors)*

Please answer all information as completely as possible. If applicable, both mother and father should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your child's counselor will discuss your responses with you after he/she has reviewed the form.

Child's Name: _____ *Date of First Visit* _____
Last First MI

*Completed by:*_____ *Relationship to Child:* _____

Home Phone:_____ (***May call***: yes__no__ ***May Leave Message***: yes__ no__)
Work Phone:_____ (***May call***: yes__no__ ***May Leave Message***: yes__ no__)
Cell Phone: _____ (***May call***: yes__no__ ***May Leave Message***: yes__ no__)
Best Time and Place to call: _____

Child's Address: _____
Street Apt. City State Zip

Child's Gender: Male___ Female___ *Date of Birth*_____ Age _____

Child's Ethnicity: Caucasian___ Africa American___ Hispanic/Latin___ Asian___ Native American___
Bi-racial___ other (explain) _____

Child's primary language: English ___ Spanish ___ other ___
Language spoken at home (parent's language) _____

Child's Legal Guardian (Managing Conservator)*:* _____
(If the child is not living with both natural parents, both adoptive parents, or only living parent, the clinic requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page). (The photocopy should be stapled to this form.)

In case of emergency, contact: _____
Name *Relationship* *Phone*

Is your child presently receiving counseling elsewhere? No___ Yes___ **(If yes, do not complete this form until you have talked with your counselor)**

Family members receiving services at this clinic (present or past): _____

Is your child currently on probation? No___ Yes___ *School Child attends:* _____

Grade Level (now): _____ Has your child ever been r*etained? No ___ Yes ___ If yes, what grade ___*
Current Teacher(s): 1) _____*2*_____ *3)* _____
Current School Counselor: _____
Current School Address & Phone _____

If your child receiving special education or other services? No ___ Yes ___ (explain) _____
Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? No___ Yes___ (If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency_____
Name Address

Phone_____ Dates of Service_____ (beginning - ending)

Has your child been hospitalized for mental health concerns No __ Yes__
If yes: When _____ Where_____

How were you referred to our clinic? (check those that apply): Physician__ School personnel__ Yellow Pages__ Family member__ Counselor/Psychologist/Psychiatrist__ Friend or Coworker__ Minister__ DPRS__ Flyer__ Newspaper Ads__ UNT Community__ Court__ Self__ Relative__ Other_____

Are you seeking services for your child because they are a victim of a crime? Yes____ No_____
Did it result in legal action? _____

Person responsible for financial arrangements with our clinic:_____

INFORMATION ON CHILD'S MOTHER

Mother's Name:_____
Last *First* *MI*
I am ___ *biological mother* ___*stepmother* ___*adopted mother other* _____

Address: _____
Street *Apt.* *City* *State* *Zip*

*Home Phone:*_____ *Work Phone:* _____
(May call: Yes/no Leave Message: Yes/No) (May call: Yes/no Leave Message: Yes/No)

*Date of Birth:*_____ *Occupation:* _____
*Employer*_____ *How Long:*_____

Last Year of education completed: 8th grade or below ___ High School ___ GED ___ Trade School ___ Some College ___ College Graduate ___ Master's Degree ___ Ph. D. Degree ____

History of learning, emotional, or behavioral problems: Yes __ No __ (If yes, please explain)
_____

History of alcohol/drug/substance abuse: Yes __ No __ (If yes, please explain)
_____

History of family violence: Yes __ No __ (If yes please explain) _____
_____

History of criminal activity: Yes __ No __ (If yes, please explain) _____
_____

Current living arrangements: Single___ Significant other___ Single parent with children___ Roommate(s)___ Married___ Married with children___ Family of origin___
Living with other relatives ___ other_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married 1_____ Separated 1_____ Divorced 1_____ Widowed 1_____
Married 2_____ Separated 2_____ Divorced 2_____ Widowed 2_____
Married 3_____ Separated 3_____ Divorced 3_____ Widowed 3_____

INFORMATION ON CHILD'S FATHER

Father's Name: _____
Last *First* *M.*
I am __ *biological father* ___*stepfather* ___*adopted father other* _____

Address: _____
Street *Apt.* *City* *State* *Zip*

Home Phone: _____ *Work Phone:* _____
(May call: Yes/no Leave Message: Yes/No) (May call: Yes/no Leave Message: Yes/No)

*Date of Birth:*_____ *Occupation:* _____
*Employer:*_____ *How long:*_____

Last Year of education completed: 8th grade or below _____ High School ___ GED ___ Trade School ___ Some College ___ College Graduate ___ Master's Degree ___ Ph. D. Degree ____

History of learning, emotional, or behavioral problems: Yes __ No __ (If yes, please explain)

_____

History of alcohol/drug/substance abuse: Yes __ No __ (If yes, please explain)

_____

History of family violence: Yes __ No __ (If yes please explain) _____

_____

History of criminal activity: Yes __ No __ (If yes, please explain) _____

_____

Current living arrangements: Single___ Significant other___ Single parent with children___ Roommate(s)___ Married___ Married with children___ Family of origin___
Living with other relatives ___ other_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____

Married 1_____ Separated 1_____ Divorced 1_____ Widowed 1_____
Married 2_____ Separated 2_____ Divorced 2_____ Widowed 2_____
Married 3_____ Separated 3_____ Divorced 3_____ Widowed 3_____

GENERAL INFORMATION

Child's current household: Mother only ___ Father only ___ Natural parents ___ Natural Mother and Step-Father ___ Natural Father and Step-Mother ___ Blended family (both spouses with children) ___ Adoptive parents __ Grandparents___ Other Relatives __ Foster family __ Institution __ Other_____

List by Household your child's current family, beginning with the oldest member and include the child:

Primary Household (anyone who currently lives with child)
How long in this current living situation: _____

Name	Age	Gender	Relationship to you (include "step", "half", etc.)

Child lives in: House_____ Apartment _____ Duplex _____ Other_____

Second Household (non-custodial or extended family - if applicable)

Name	Age	Gender	Relationship to you (include "step", "half", etc.)

Currently involved in a custody dispute: No __ Yes __ (If yes, explain) _____

_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly
__1_____2_____3_____4_____5

How often does client see non-custodial parent? _____
_____

CHILD'S HEALTH

Child's Primary Care Physician: _____
Name Phone

_____
Address

*Date of LAST complete physical*_____

Has your child ever seen a psychiatrist? Yes____ No____
Is child currently seeing a psychiatrist? Yes____ No____ (If yes list name and address and phone):

_____
Name Phone

_____
Address

Physical Disability: Yes __ No ___ (If yes, explain) _____

Chronic Illness: Yes ___ No ___ (If yes, explain) _____

Terminal Illness: Yes ___ No ___ (If yes, explain) _____

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____

Addictions	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If your child has been diagnosed, who gave the diagnosis? Pediatrician____ Psychiatrist___ School____

Other _____

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT CONCERNS

Indicate severity of up to 10 items that currently apply to your child. (1-mild; 2-moderate; 3-severe) Circle the item that you see as the most significant issue)

___Adjustment to life changes (changing schools, parent's divorcing, moving, getting married or divorced, aging, etc.)
___Bed wetting daytime wetting, soiling or related problems
___Career Decisions
___Abuse (physical, emotional, sexual)
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling angry or irritable
___Feeling guilty or shameful
___Feeling sadness or depression related to grief
___Feeling sadness or depression NOT related to grief
___Gang related concerns (explain_____)
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
___Learning/Academic difficulties
___Personal Growth (no specific problem)
___Parent-Child relationship (discipline, adoption, single parent, etc.)
___Family or Step-family relationship problems
___Non-family relationship problems (teachers, peers, etc.)
___Religious or Spiritual concerns
___Sexual concerns (excessive masturbation, inappropriate acting out)
___Sexual identity concern
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Suicidal Ideation (thoughts of death, wanting to die)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Other (explain_____)

***Remember to circle the most significant issue.**

*When did you first become concerned about this issue?*_____

How have you attempted before now to deal with these issues? _____

_____

Other treatment your child or your family has received to address any of the concerns you indicated above: None___ Individual counseling___ Family counseling___ Group counseling___ Couples Counseling___ Hospitalization___ School Counseling__ Other (explain) _____

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

*Anything else you think we need to know*_____

What is the one thing I need to know to help your child today? _____

FAMILY HISTORY/EXPERIENCES

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

Raised by: Natural parents___ Single natural parent___ Grandparents___ Adoptive parent(s)___ Natural and step-parent___ Foster parents___ Institution___ Relatives___ Other_____

Stressors in the Family: Parents fighting frequently___ Parents divorced___ Financial problems___ Family member's disability or major accident or illness___ Chronic illness of family member___ Moved a lot___ Family member absent (explain)_____ _____ Death of significant person___ Family member suicide(explain)_____ _____
Family member emotional problems (explain) _____ other (explain) _____

History of your child having learning, emotional, behavioral problems: yes__ no__
(If yes, please explain) _____

History of your child having alcohol/drug/substance abuse: yes__ no__
(If yes, please explain) _____

History of family violence: yes__ no__
(If yes, please explain) _____

History of criminal activity in the family: yes__ no__
(If yes, please explain) _____

Has your child been abused (check all that apply): Physically___ Emotionally___ Sexually___

Has your child been neglected (check all that apply): Physically___ Emotionally___

School Problems (check all that apply): Academic problems___ Severely teased___ Discipline problems___ Unpopular___ other (explain_____)

Early Language/Speech Problems (explain_____)

History of emotional concerns include: Emotional problems___ Suicidal thoughts___ Suicide attempts___ Loss of energy or fatigue___ Lost weight___ Gained weight ___ Appetite change ___ Heard voices when no one was around ___ other (explain) _____

History of behavior problems include: (check all that apply): Misbehaved a lot___ Trouble with the law___ Involved with the juvenile system___ Ran away___ Impulsive___ Alcohol and/or drug use___ Hyperactive___ Attention problems___ Accident-prone___ Frequent arguments___ Taken advantage of___ Temper outbursts___ Aggression___ Loner___ Other _____ _____

History of anxiety symptoms include: (indicate all that apply): Obsessive worrying ___ Keyed up, on edge ___ Phobias ___ Irritable ___ Physical symptoms (below) ___ other _____
History of health/physical problems include: (check all that apply): Headache (kind) ___ Nervous stomach ___ Diarrhea ___ Bone/joint/muscle ___ PMS ___ Dizziness ___ Shortness of breath without exertion ___Heart Palpitations ___ Chest pain

___ Surgeries ___ Major illness___ Major accident___ Disability___ Chronic illness___ Hospitalization___ Developmental delay(s)___ Sleep problem___ Bedwetting___ Serious overeating or undereating___ Neurological problems/exam___ Asthma___ Other_____

History of trauma/stressor include: (check all that apply): Child separated from parent (how long and when)_____ Death of a significant person___ Death of a pet___ Incarcerated family member___ Sexual Assault___ Victim of trauma (unusual, terrifying experience)___ Medical___ Natural Disaster___
Other _____

History of interpersonal problems include: (check all that apply): Frequent arguments___ Taken advantage of___ Temper outbursts___ aggressive behavior___ Loner___ Other_____
_____

Family Atmosphere (circle the number that best describes how you view your child's current family atmosphere)

Very lenient	1 2 3 4 5	Very strict
Very non-religious	1 2 3 4 5	Very religious
Chaotic	1 2 3 4 5	Highly structured
Few expectations	1 2 3 4 5	High expectations
Inconsistent	1 2 3 4 5	Consistent

Family Support System (such as church, friends, relatives, school)

Hardly any support	1 2 3 4 5	Considerable support

Your child's current use of Computer, VCR, and Television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

_____
Child's Name

_____ _____
Parent/Guardian Signature Date