



# Center for Biofeedback and Behavior Therapy

4530 Beltway Rd.  
Addison, TX 75001  
(469)358-1309  
[www.cbbt.org](http://www.cbbt.org)

## 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 retained? 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 \_\_\_\_\_



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