Child Background Information

Certified Behavioral Health Centers are required by the State of Ohio and other authorities to request the following information from our clients. Please answer the following questions as completely as you can. The staff person you work with will review them with you and answer any questions you may have. This information will be kept confidential unless you provide written permission to share it or we are required to release it by court of law.

CHILD INFORMATION

Name: ____

Last First MI

SS#__________/__________/________________ Birth Date: _______/_______/_____________ Sex: Male_____ Female_____

Address: ____

Street City State Zip County

School: ____Grade: _______________

Mother ____ Phone #_____________________________

Father ____ Phone #_____________________________

Legal Guardian____ Phone # _____________________________

Employer____ Total Family Income $_____________________

May we contact you at Yes__ No __ Home #: ______________________ Yes__ No __ Work #: ____________________________

Yes __ No __Cell #: _________________________________ May we contact you through Text messaging: Yes ___ No ___

Emergency contact person other than parent or guardian__________________________________ Phone # ____________________

SIBLINGS

1. ____ _____ In home _____ Outside of home

Name Age

2. ____ _____ In home _____ Outside of home

Name Age

3. ____ _____ In home _____ Outside of home

Name Age

RACE AND ETHNICITY

Race: ___African-American ___Alaskan ___American Indian ___Asian ___Hawaiian ___White ___Unknown

Ethnicity: ___ Not Hispanic nor Latino ___Mexican ___Cuban ___Puerto Rican Other________________________

CURRENT SYMPTOMS

Please check any of the following which have been a problem or concern in the past 2-4 months:

____Sleeping Problems
___ Lying
___ Stealing
___Appetite or Eating Problems
___ Sadness, Tearfulness
___ Anxiety, Nervousness
___ Panicky or Panic Attacks
___ Oppositional
___ Argumentative
___ Grief or Loss
___ Nightmares

___ Loss of pleasure/Interest
___ Destruction to Property
___ Poor Self-Esteem/Image
___ Attention Problems
___ Hyperactive
___ Domestic Violence in Home
___ Anger, Hurting Others
___ Alcohol or Drug Use
___ Sexual Concerns
___ Legal Problems/Probation

___ Work/School Conflict
___ Parents Divorce
___ Peer Relationship Problems
___ Thoughts about Harming Self
___ Thoughts about Harming Others
___ Other Odd or Troubling Thoughts
___ Hearing Voices/Seeing Things
___ Memory Problems
___ Withdrawn/Isolated
___ Court or CSB Requires

___ Headaches
___ Hearing
___ Coordination
___ Fainting Spells
___ Skin Problems
___ Chest Pain
___ Menstrual Pain

___ Constipation
___ Diarrhea
___ Nausea
___ Frequent Infections
___ Swallowing
___ Dental
___ Back Pain
___ Breathing

___ Soiling
___ Bed Wetting
___Genital Pain or Soreness
___ Numbness
___ Unusual Tiredness
___ Abdominal Pain
___ Visual
___ Other___________________

PAST MEDICAL INFORMATION

Allergies: Yes ___ No___ If yes, please explain: ____

Current medication(s) ____

Does your child have any physical or developmental disabilities? Yes ___ No___

Is your child a victim of physical or sexual abuse? Yes ___ No___

Is there a history of head injury? Yes ___ No___ explain ____

Is there a blood relative history of major disease or illness? Yes ___ No___ explain____

Known history of alcohol or drug use/abuse ___ Yes ___ No

BIRTH HISTORY OF CHILD

Were there any significant problem with pregnancy or delivery of this child? Yes ___No___

Did biological mother use/abuse drugs or alcohol during pregnancy? Yes ___ No___

Has child (if female) ever been pregnant? Yes ___ No___

Child's developmental milestones were: achieved successfully ___ somewhat delayed ___ chronically late___

DESCRIBE YOUR CHILD'S INVOLVEMENT IN:

Your home:____

Leisure & recreation:____

Church:____

Hobbies/general interests:____

General social life:____

OTHER AGENCY INVOLVEMENT

Please list any other agencies currently involved with your child or family:

Agency/Person____

Beginning Date____ Ending Date ____

If so, Please complete a Release of Information for the agency(s) and or the individual(s)

SUMMARY OF NEEDS:

Explain why you need our services:

____
____
____
____
____
____
____
____
____
____

THANK YOU