WENTWORTH HEALTH PARTNERS

Behavioral Health – Minor Biographical Information Form

Child's Name: _____ Date of Birth: _____ Age: _____

Address: _____ Telephone #: _____

_____

Mother's Name: _____ Telephone #: _____

Address: _____

Father's Name: _____ Telephone #: _____

Address: _____

Marital Status of Parents: _____

Do biological parents live together? **Yes** ☐ **No** ☐ Are the parents divorced? **Yes** ☐ **No** ☐

If parents are separated or divorced, is there a custody agreement concerning who may make decisions for medical care? _____

Joint custody? **Yes** ☐ **No** ☐ Joint custody with provisions? **Yes** ☐ **No** ☐

If yes, please explain special provisions: _____

_____

Are parental rights limited or terminated for either parent by court order? **Yes** ☐ **No** ☐

How? _____

_____

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Siblings: **Name(s)**

_____ Age: _____

_____ Age: _____

_____ Age: _____

Others Living with the Family:

Name(s)

_____ Age: _____

_____ Age: _____

_____ Age: _____

What brings you to our practice today? _____

_____

Onset of these problems: _____

_____

Any previous psychological treatment for child or other family member? _____

Developmental History

How would you describe the pregnancy with your child? _____

_____

Full term? **Yes** □ **No** □ Complications: _____

_____

What age did your child: Crawl _____ Walk _____ Talk _____ Toilet train _____

Highlight complications: _____

_____

How did your child separate for daycare or school? _____

_____

How long did it take to adjust to separation? _____

_____

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School History

Current school: _____

Special Education or Special Needs student? **Yes** □ **No** □

Explain: _____

Does the child have an Individual Education Plan, or is he/she coded? _____

How would you describe current progress? _____

_____

How would you describe past school behavior and progress? _____

_____

Is the child frequently absent from school? _____ If yes, please explain: _____

_____

Please highlight special achievements or problems in elementary school: _____

_____

In middle school: _____

In high school: _____

Has the child skipped any grades? _____

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Problem / Symptom Checklist

☐	Withdrawn at home & with peers	☐	Alcohol / drug abuse
☐	Isolated	☐	Attention difficulty
☐	Irritable	☐	Tics or unusual movements
☐	Can't settle down	☐	Overly aggressive—hits or bites others
☐	Self-critical	☐	Stealing—inside or outside home
☐	Sleep problems	☐	Bedwetting – after being fully trained
☐	Nightmares	☐	Poor personal hygiene
☐	Sudden drop in school grades	☐	Unusual beliefs
☐	Sudden change of friends	☐	Unusual fears
☐	Sexual / physical abuse	☐	Other _____

Trauma History

Has your child ever been the victim of trauma? (Please circle all that apply)

Physical Abuse Sexual Abuse/molestation Witness to Violence Emotional/verbal Abuse

Any experiences, deaths or major losses in your child's life that have been particularly hard? ____

_____

_____

Is there any important information you want me to know that we have not asked? _____

_____

_____

_____

What goals do you have for your child and/or family? _____

_____

_____

_____

What would you most want to see happen from this treatment? _____

_____

_____

_____

Name: _____ Date:_____

SYMPTOM CHECKLIST

Please check the column that best describes how frequently you have experienced each of the symptoms below. Use the last column to notate the 3 symptoms that bother you the most.

SYMPTOM	Never	Seldom	Sometimes	Very Often	Note with an * the 3 most bothersome
Depressed mood					
Intense fears (planes, heights, elevators, etc.)					
Unwanted thoughts					
Doing things over and over					
No memory for blocks of time					
Hearing things not there					
Seeing things not there					
Suspiciousness					
Difficulty sleeping					
Eating difficulty					
Difficulty concentrating					
Anxiety					
Feeling panicky					
Frequent nightmares					
Wanting to harm yourself					
Difficulty with memory					
Excessive picking/scratching					
Unusually high energy					
Excessive drug/alcohol use					
Tremors					
Fear of social situations					
Fear of being overweight					
Vomiting/purging					
Uncontrollable temper					
Aggressive impulses					

SYMPTOM CHECKLIST – continued

SYMPTOM	Never	Seldom	Sometimes	Very Often	Note with an * the 3 most bothersome
Flashbacks					
Excessive risk taking					
Self-injurious behavior					
Disorientation					
Impulsivity					
Low energy					
Low self-esteem					
Mood swings					
Premenstrual symptoms					
Fear of leaving home					
Problems with partner					
Fear of dying					
Physical pain					
Fear of being sick					
Feeling detached from others					
Addictive behavior					
Feeling uneasy in public					
Other: List Below					