Date Completed: _____

BALTIMORE THRIVES, LLC
BACKGROUND INFORMATION

PATIENT NAME: _____
BIRTHDATE:
AGE: _____
GENDER:

Referral Source:

Reason for Referral:

Family Information:

Legal Guardianship of Child: (circle one) Parent Adoptive Grandparent Other- _____
Described Guardianship (If Applicable):

Father's Name: Occupation:

Mother's Name: Occupation:
Status of Parents: (circle one)

Parents Married Cohabitating Separated Divorced Deceased Mother/Father
Remarried Mother single/Father single Mother in relationship/Father in relationship

Step-parent's Name: (if applicable)

Names/ages of Siblings:

Address:

Living Conditions (e.g. changes in custody, family composition, death, parental separation, new births):
_____
_____

Phone Numbers:	**Mother**	**Father**	**Child**
Home-			
Work-			
Cell-			

Father's Email Address: _____
Mother's Email Address: _____
Child's Email Address: _____

Background information:

Describe Your Child's Strengths:

Describe Your Child's Concerns:

History:

Pediatrician: **Phone:**

Pediatrician's Office Name:

Birth: Complications during pregnancy- **YES NO**
Medications during pregnancy- **YES NO**
Alcohol or drugs- **YES NO**
Complications during labor and delivery- **YES NO**
Full Term- **YES NO**

Weight- _____lbs _____oz
Other (jaundice, supplemental oxygen, C-Section, labor induced, time in NICU, etc):

Describe Any Delays During Early Development: (e.g. Walking, talking, playing, toileting, socialization)

History: (Medications, broken bones, concussions, seizures, surgeries, hospitalizations, emergency room visits, significant injuries, significant illnesses, physical or sexual abuses, asthma, allergies, etc.)

	Condition	Month/Year	Reason
1.			
2.			
3.			
4.			
5.			

Current Medications Being Taken:

1.	Dosage/Freq	Start Date	Purpose
2.	Dosage/Freq	Start Date	Purpose
3.	Dosage/Freq	Start Date	Purpose

Prescribing Doctors:

Current or Upcoming Treatments/Medications/Surgeries for Medical Conditions:

Rate Your Child's Current Health: (circle one) **Below Average** **About Average** **Above Average**

General Health: What if any conditions affect your child's health?

Previous Mental Health Assessments/Treatments:

	Service Provider	Month/Year	Reason
1.			
2.			
3.			

Suicide Attempts: Has your child ever talked about or attempted any behaviors related to suicidal acts? If so, describe incident(s) and resulting action(s) (e.g. hospitalization, medication, etc)?

Self-Injurious Behaviors (Cutting, burning, carving, hitting self, etc.):

Legal History (arrests, citations, detentions, pending court dates, probations):

Substance Use History (If any):

Family Medical/Mental Conditions: (e.g. depression, anxiety, suicide, substance abuse)

–

Educational Information:

Name of School:
Grade:
School Staff Contact:
Phone:

Attendance History/Frequent School Changes: YES NO If yes, why?

Discipline and Attendance Record: (e.g. expulsions, suspensions, parent conferences, absenteeism, tardiness)

Any Comments or Statements Made to You By Educators About Your Child's Abilities or Learning:

Did Your Child Make Satisfactory Progress in Kindergarten and First Grade: YES NO If no, why?

Was Your Child Ever Retained a Grade Level: YES NO If so, why and when?

Strengths in School:

Concerns in School:

Child's Attitude Towards School:

What Factors Impact Your Child's Ability to Learn?:

Current Supports in School: (e.g. 504 Plan, after school activities, pull-out interventions for academics or behavior, Behavior Intervention Plans, Special Education)

Prior Psychoeducational Testing: ***Please bring copies of reports to our first meeting.***

	School District or clinician	Month/Year	Reason
1.			
2.			
3.			

Problems With:

__ Reading __ Math __ Written Language __ Oral Language __ Spelling __Work Completion
__ Understanding Directions __Oral Comprehension __ Content Area __ Homework Completion
__ Organization/Preparedness __ Vocabulary __ Other: ___

Educational Goals and Aspirations:

Social Relationships:

How Does Your Child Relate to Others: (Peers and adults)

Does Your Child have Frequent Conflicts or Fights with Siblings/Peers:

Does Your Child Prefer to Socialize with Older/Younger Children:

Does Your Child Prefer to be Alone:

Does Your Child have Difficulty Making Friends:

Participates in Organized Activities/Church/Sports/Clubs:

Hobbies and Interests:

Other:

Symptom Present/Description/History:

Attention/Concentration/Hyperactivity:

<u>Mood/Anxiety/Affective:</u>

<u>Somatic/Physical Complaints:</u>

<u>Interpersonal/Social Skills:</u>

<u>Other:</u>

What would you like to learn from the present assessment/treatment of your child and then describe your therapy goals for your child:

Notes:

Clinician/Psychology Associate Signature ***Date***

Licensed Psychologist/Supervisor Signature ***Date***