The Office of
James G. Wellborn, Ph.D.
Child, Adolescent & Family Psychologist

Child & Adolescent Background Information

Please complete **EVERY SECTION** of this questionnaire about the person receiving treatment. This information is very important for developing a complete understanding of areas that can influence most problems. This and all other information you provide is confidential and private. Any unanswered sections will require taking valuable time out of the first meeting to gather this information.

GENERAL INFORMATION

Client's Full Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

SS# _____-____-_____ Age _____ Sex ___ Cell Phone: _____ Living with _____

Mother's Name _____ Telephone H: (___) _____ W: (___) _____

SS# _____-____-_____ Birthdate: _____ Mother's Cell Phone: (___) _____

Address _____ City _____ State _____ Zip _____

Father's Name _____ Telephone H: (___) _____ W: (___) _____

SS# _____-____-_____ Birthdate: _____ Father's Cell Phone: (___) _____

Address _____ City _____ State _____ Zip _____

Pediatrician or Family Physician _____ Telephone (___) _____

I understand that this physician may be contacted. ☐ Yes _____ (Initial) ☐ No _____ (Initial)

I. **REASONS FOR SEEKING HELP**

Please give a complete statement below of your concerns and any concerns expressed by teachers or others that led to your seeking treatment. Begin by describing the most important concern first.

1. _____

_____

2. _____

_____

3. _____

How long have you been concerned about these problems? _____

Please mark all of the following descriptions that apply to the client now or in the past.

Now	Past		Now	Past	
☐	☐	Alcohol Abuse	☐	☐	Tension and Stress
☐	☐	Drug Abuse	☐	☐	Crying Spells
☐	☐	Arrests	☐	☐	Fears
☐	☐	Sleep Problems	☐	☐	Loneliness
☐	☐	Nightmares	☐	☐	Suicidal Thoughts or Attempts
☐	☐	Sexual Problems	☐	☐	Sexually Abused
☐	☐	Appetite Changes	☐	☐	Threats or Attempts to Harm Others
☐	☐	Weight Changes	☐	☐	Obsessions
☐	☐	Anger Outbursts	☐	☐	Difficulty Concentrating
☐	☐	Depression	☐	☐	Hearing Voices
☐	☐	Anxiety	☐	☐	Suspicions About Others
☐	☐	Physically Abused	☐	☐	Racing Thoughts
☐	☐	Mood Swings	☐	☐	Preoccupation with Physical Problems
☐	☐	Low Energy	☐	☐	Other: _____

II. FAMILY HISTORY

	Mother Natural, foster, adoptive or step **(circle one)**	Father Natural, foster, adoptive or step **(circle one)**
Age	_____	_____
Occupation	_____	_____
Current employer	_____	_____
Last school grade completed	_____	_____
Date of present marriage/partnership	_____	_____
Dates(s) of prior marriage(s)/partnership(s) and divorce(s)	(1) Mar _____ Div _____ (2) Mar _____ Div _____	(1) Mar _____ Div _____ (2) Mar _____ Div _____

Who has current **legal** custody? ☐ Both ☐ Mother ☐ Father ☐ Joint ☐ Other _____

Learning difficulties:	Mother:	☐ Yes	☐ No	If "yes," please describe _____
	Father:	☐ Yes	☐ No	If "yes," please describe _____
Behavior problems:	Mother:	☐ Yes	☐ No	If "yes," please describe _____
	Father:	☐ Yes	☐ No	If "yes," please describe _____
Medical problems:	Mother:	☐ Yes	☐ No	If "yes," please describe _____
	Father:	☐ Yes	☐ No	If "yes," please describe _____
Alcohol/Drug problems:	Mother:	☐ Yes	☐ No	If "yes," please describe _____
	Father:	☐ Yes	☐ No	If "yes," please describe _____

Please list brothers and sisters of the client starting with the oldest. (Please include <u>all</u> siblings--step, ½ , deceased etc.)

Name	Birthdate	Age	Sex	Grade in School

Please list any other people living in your home and briefly describe how they came to live there.

_____

Please indicate which, if any, of the client's blood relatives have experienced any of the following:

			Relationship to Client
1. Learning difficulties (reading, math or writing).	□ Yes	□ No	
2. Attention Deficit Disorder (with or without hyperactivity)	□ Yes	□ No	
3. Excessive alcohol and/or drug use	□ Yes	□ No	
4. Emotional problems	□ Yes	□ No	
5. Seizure disorder	□ Yes	□ No	
6. Migraine headaches	□ Yes	□ No	
7. Allergies	□ Yes	□ No	
8. Legal problems	□ Yes	□ No	

III. DEVELOPMENTAL HISTORY

A. Did the client's biological mother experience any complications during pregnancy (e.g., hospitalization, threatened miscarriage, infections, operations, illnesses, alcohol or drug use, cigarette use, etc.)

□ No □ Yes (Please describe _____)

Length of pregnancy: □ Full Term □ Premature (__ weeks old at birth) □ Late (__ weeks old at birth)

B. Father: Any pertinent medical/cigarette/drug use _____

C. Delivery: □ Normal □ Complications (Please describe _____)

D. Infancy-Toddler period (1-24 mos.)	No	Yes	Very Much
Enjoyed cuddling	□	□	□
Calmed by holding or stroking	□	□	□
Colic	□	□	□
Active, into everything	□	□	□
Restless or easily aroused during sleep	□	□	□
Difficulty falling asleep or awakened quickly	□	□	□
Hard to arouse while asleep	□	□	□
Nightmares	□	□	□
Sleepwalking	□	□	□
Head-banging	□	□	□
Accident Prone	□	□	□
Sensitive to noises, light, texture, clothing	□	□	□
Breathing problems (e.g., SIDS, etc.)	□	□	□
Easy going, good tempered	□	□	□
Reacted poorly to change in routine	□	□	□
Reacted to new foods, places, or people	□	□	□
Intense and/or loud	□	□	□
Unpredictable in feeding and sleeping	□	□	□
Fussy and unhappy	□	□	□

E. Childhood Milestones

Please indicate the age at which the client reached the following developmental milestones. If you cannot recall the exact date, please estimate by checking one of the categories at right.

	Age	Early	Average	Late
Smiled	_____	☐	☐	☐
Crawled, stood without support, walked	_____	☐	☐	☐
Spoke first words, said phrases and sentences	_____	☐	☐	☐
Bowel and bladder control	_____	☐	☐	☐
Rode bicycle (without training wheels)	_____	☐	☐	☐
Named colors, said alphabet, began to read	_____	☐	☐	☐

F. Coordination

	Good	Average	Poor
Walking	☐	☐	☐
Running	☐	☐	☐
Throwing	☐	☐	☐
Catching	☐	☐	☐
Shoelace tying	☐	☐	☐
Buttoning	☐	☐	☐
Writing	☐	☐	☐
Athletic abilities	☐	☐	☐

List sports enjoyed _____

List sports in which he/she excels _____

G. Adolescent Milestones

	Early	Average	Late	Not Achieved
Disagrees without making things worse	☐	☐	☐	☐
Assertiveness without aggression	☐	☐	☐	☐
Assumes responsibility for behavior	☐	☐	☐	☐
Can see other's point of view	☐	☐	☐	☐
Accurately identifies emotions	☐	☐	☐	☐
Establishes close friendships	☐	☐	☐	☐
Personally responsible for school/grades	☐	☐	☐	☐
Recognizes personal strengths	☐	☐	☐	☐
Actions guided by sense of right/wrong	☐	☐	☐	☐
Effective problem solving under stress	☐	☐	☐	☐
Ideas about preferred career path	☐	☐	☐	☐

H. Sleep History

	No	Yes	Very Much
Does the client snore when sleeping?	☐	☐	☐
Has the client ever stopped breathing during sleep?	☐	☐	☐
Does the client regularly fall asleep during school or while watching TV?	☐	☐	☐
Do you have a difficult time waking the client from sleep?	☐	☐	☐

IV. **MEDICAL AND PSYCHOTHERAPY HISTORY**

Date of last complete physical examination _____ Physician _____

Current health concerns or medical problems _____

_____

Immunized against all communicable diseases □ Yes □ No (If "No", please explain) _____

Complications from any childhood diseases (Please describe) _____

_____

Hospitalizations _____

_____

_____

Head injuries (with or without unconsciousness), seizures, convulsions (with or without fever), coma, meningitis, or encephalitis (Please indicate the age and describe the events in detail) _____

_____

Seizures or "absent" episodes (Please indicate the age these occurred) _____

Allergies or reactions to medication _____

Past Psychiatric Medications: _____

Current Medications:	Drug Name	Dosage	Taken For How Long	M.D.

Psychiatric Hospitalizations:	Year	Reason	Hospital

Client's prior experience with counseling, psychotherapy, or treatment for chemical dependency

Year____ Agency or Clinician _____ Length of Treatment _____

Year____ Agency or Clinician _____ Length of Treatment _____

Year____ Agency or Clinician _____ Length of Treatment _____

Year____ Agency or Clinician _____ Length of Treatment _____

Previous reactions to psychological or medical care? □ Positive □ Negative _____

_____

V. EDUCATIONAL AND WORK HISTORY

Current school _____ Grade _____

Has the client repeated any grades: □ No □ Yes If "yes," which ones: _____

Is the client able to read? □ Yes □ No write? □ Yes □ No

At this time the client's grades in school are primarily: □ A's & B's □ B's & C's □ C's & D's □ D's & F's

Has the client's performance in school gotten worse recently? □ Yes □ No

Do the client's grades in school vary dramatically from day to day? □ Yes □ No

Has the client ever been suspended or expelled from school? □ Yes □ No

If so, for what reason(s)? _____

_____

Has the client had a psychological evaluation by the school? □ Yes □ No

(Please bring recent report cards, achievement tests, and any psychological or achievement test reports with you)

Does the client receive any special education assistance for conditions such as a learning disability, behavior disorder, emotional handicap, etc. □ No □ Yes

If "yes," what kind of assistance is provided? _____

_____

List the schools the client has attended: (If more space is needed, use reverse side)

Kindergarten _____

Elementary _____

_____

_____

Middle School/Jr. High _____

_____

_____

High School _____

_____

College _____

Rate how the client currently feels about school:

□ Very Positive □ Positive □ Indifferent □ Negative □ Very Negative

How would you rate the client's overall level of intelligence compared to other children?

□ Below Average □ Average □ Above Average

Has the client ever received tutoring or special therapy? □ Yes □ No If so, please specify: _____

_____

Client's current job position _____ Hours worked per week _____ Length of Employment _____

List all jobs held in the past 12 months _____

Please note in each category whether the client has had no difficulty, difficulty throughout his/her school experience, or only recent difficulty.

	No Difficulty	Difficulty Throughout	Recent Difficulty
Reading Skills	{ }	{ }	{ }
Math Skills	{ }	{ }	{ }
Social Science	{ }	{ }	{ }
Science	{ }	{ }	{ }
Handwriting	{ }	{ }	{ }
Not wanting to go to school	{ }	{ }	{ }
Staying on task	{ }	{ }	{ }
Completing class work	{ }	{ }	{ }
Working too slowly	{ }	{ }	{ }
Working too quickly	{ }	{ }	{ }
Conflict with teachers	{ }	{ }	{ }
Not following class rules	{ }	{ }	{ }
Interrupting	{ }	{ }	{ }
Fighting	{ }	{ }	{ }
Getting out of seat	{ }	{ }	{ }
Following oral directions	{ }	{ }	{ }
Following written directions	{ }	{ }	{ }
Organizing materials and tasks	{ }	{ }	{ }
Completing work neatly	{ }	{ }	{ }

VI. **RELATIONSHIPS, BEHAVIOR AND ACCOMPLISHMENTS**

A. Peer Relationships

	Yes	No
Does the client play/interact well with peers of many different ages?	□	□
Does the client play/interact primarily with older peers?	□	□
Does the client play/interact primarily with younger peers?	□	□
Does the client experience problems with peers?	□	□

Describe briefly _____

_____

Who are the people that provide the client with emotional support? _____

B. Religious History

How central are religious beliefs to your family? □ Very Important □ Kind of Important □ Not Really Important

Do you attend church regularly? □ No □ Yes (If "Yes", what denomination _____)

C. Home Behavior

Check the behaviors listed below the client exhibits to an excessive or exaggerated degree when compared to other people his/her age.

- □ Hyperactivity (high activity level)
- □ Poor attention span
- □ Impulsivity
- □ Low frustration threshold
- □ Temper outbursts
- □ Interrupts frequently
- □ Doesn't listen when spoken to
- □ Sudden outbursts of aggression toward other children
- □ Withdrawn
- □ Acts as though "driven by a motor"
- □ Wears out shoes more frequently than siblings
- □ Spends free time by him/herself
- □ Needs to be entertained during free time
- □ Heedless of danger
- □ Excessive number of accidents
- □ Doesn't learn from experience
- □ Poor memory
  - □ More active than siblings
- □ Destroys toys or possessions

D. Interests and Accomplishments

What does the client enjoy doing most? _____

_____

What does the client dislike doing most? _____

_____

What are the client's strengths, special skills, or abilities? _____

□ Kind	□ Sense of Humor	□ Compassionate
□ Generous	□ Athletic	□ Gentle
□ Hard Working	□ Dependable	□ Helpful
□ Persistent	□ Interested in Relationships	□ Independent
□ Attractive	□ Dedicated	□ Trustworthy
□ Tough	□ Good Hearted	□ Up-beat & Positive
□ Ambitious	□ Family-oriented	□ Good with people
□ Energetic	□ Passionate	□ Intelligent
□ Thoughtful	□ Insightful	□ Street smart
□ Open-minded	□ Accepting of others	□ Loyal
□ Creative	□ Mechanically-oriented	□ Sincere

E. Diet and Physique

How many caffeinated drinks does the client consume in a typical day? _____

Does the client take daily multi-vitamins □ Yes □ No

Describe the client's appetite: □ Good □ Picky Eater □ Poor Appetite □ Overeats

What does the client eat for snack foods in a typical day? _____

_____

How would you describe the client's body type?

□ Very Thin □ Thin □ Average □ Stocky □ Very Stocky

VII. LEGAL HISTORY

Client has been involved with the law? □ Yes □ No

Number of arrests or juvenile petitions filed _____

Please list any charges that have been associated with these arrests or petitions.

Year _____ Charges _____

Year _____ Charges _____

Year _____ Charges _____

Please list any lawsuits, divorce actions, child custody actions, or any other legal actions currently pending that relate to either the client or his or her immediate family _____

VIII. OTHER FACTORS

Describe any factors not covered in this form that you think are important for understanding the client.

_____

_____