Beacon Psychology Services LLC

Youth Background Information Form

Child's Name: _____ Preferred name: _____

Today's Date: _____ Person completing form: _____

What are your primary concerns regarding your child/specific questions you would like help with?

_____

_____

_____

_____

_____

_____

When did you first become concerned about your child?

_____

_____

Early Developmental History:

Is this child your biological child or adopted? (circle) *biological* *adopted*

If adopted, at what age did you adopt this child? _____

If adopted, please list country of birth for this child: _____

Did the pregnancy have any complications? No Yes: (explain) _____

_____

How long was the pregnancy? _____ Baby's birth weight: _____

Were there any difficulties caring for this child during the first year? No Yes: _____

_____

Did you seek any services, such as First Steps, in the first 3 years? No Yes: _____

_____

_____

Please list the age your child reached the following milestones:

said first word: _____ used simple sentences: _____

sat up alone: _____ crawled: _____ walked alone: _____

toilet trained during day: _____ dry at night: _____

Medical History:

Is this child currently taking any medication? No Yes (list name and dosage): _____

_____

Please circle yes/no for a history of any of the following, and explain if yes:

Allergies	No	Yes: _____
Hearing problem	No	Yes: _____
Vision problem	No	Yes: _____
Hospitalization	No	Yes: _____
Serious accident	No	Yes: _____
Serious illness	No	Yes: _____
Chronic illness	No	Yes: _____
Seizure	No	Yes: _____
Tics	No	Yes: _____
Night terrors	No	Yes: _____

Please circle yes/no for the following <u>current</u> concerns, and explain if yes:

Eating problems	No	Yes: _____
Sleep problems	No	Yes: _____
Bedwetting	No	Yes: _____
Stomachaches	No	Yes: _____
Headaches	No	Yes: _____
Menstrual cycle	No	Yes: _____

Please circle yes/no for any of these services that your child is receiving, or did receive in the past:

Speech/language therapy	No	Yes: _____
Occupational therapy	No	Yes: _____
Physical therapy	No	Yes: _____
Counseling	No	Yes: _____
Educational tutoring	No	Yes: _____

Educational History:

Name of current school: _____ Grade: _____

Circle if your child has any of the following: *GEI* *504* *IEP*

If your child has an IEP, circle the classification: *SLD* *ASD* *SI* *LI* *OHI* *ED* *Mi/MoMD*

If your child has an IEP, what services are provided: _____

_____

_____

What grades, or GPA, does your child currently have? _____

Circle your child's most recent ISTEP: English: *passed* *failed* Math: *passed* *failed*

Did your child ever repeat a grade? (circle): No Yes (what grade):_____

Please list all schools your child attended; list for what grades if s/he attended more than one school. If you homeschooled your child for any of these years, please note this as well:

Preschool: _____

Elementary: _____

_____

Middle school: _____

Intermed/Junior High: _____

High School: _____

Has your child had any testing through the school? No Yes (when): _____

Have you sought testing for educational concerns anywhere? No Yes (when): _____

Is homework completion an area of concern? No Yes (explain): _____

_____

Has the school contacted you about behavior concerns? No Yes (explain): _____

_____

Social History:

List all extracurricular activities (sports, clubs, etc) that your child has been involved with over the last 6 months: _____

_____

List the activities/toys your child enjoys in free time: _____

_____

Does your child entertain him/herself well? No Yes (explain): _____

Do you have any concerns about your child's social development? No Yes (explain): _____

_____

How is your child getting along with siblings and parents? _____

_____

_____

How is your child getting along with other children his/her age? _____

_____

_____

What do you think of your child's closest friends/peer group? _____

_____

Do you have any concerns about alcohol/drug use? No Yes (explain): _____

_____

Have there been any legal problems? No Yes (explain): _____

_____

Are you concerned about sexual activity? No Yes (explain): _____

_____

Family Information:

Please list who has legal guardianship of this child: _____

Please circle parents' marital status: *Never married* *Married* *Separated* *Divorced* *Widowed*

If parents are separated, divorced, or widowed, please explain when this occurred: _____

_____

If parents are separated or divorced, please describe the custody arrangements: _____

_____

_____

If one of the parents is NOT living in the child's primary home, please explain the frequency of contact: _____

_____

Please list all persons living in the child's primary home:

Name of person	Relationship to child	Age	Gender (M/F)	Highest grade/degree

If any immediate family member (e.g., parent, sibling) is living elsewhere, please list:

Name of person	Relationship to child	Age	Gender (M/F)	Highest grade/degree

Please circle yes/no for any of the following in the last year, and explain if yes:

Family move	No	Yes: _____
Marital problems	No	Yes: _____
Serious parent illness	No	Yes: _____
Serious sibling illness	No	Yes: _____
Serious accident to family member	No	Yes: _____
Parent job difficulties	No	Yes: _____
Death of close family member	No	Yes: _____

Please circle yes/no for a family history of the following, and if yes then list who had these issues:

Learning difficulties	No	Yes (who): _____
ADHD/ADD	No	Yes (who): _____
Anxiety problems	No	Yes (who): _____
Depression	No	Yes (who): _____
Bipolar disorder	No	Yes (who): _____
Suicide attempt	No	Yes (who): _____
Drug/alcohol problem	No	Yes (who): _____
"Nervous breakdown"	No	Yes (who): _____
Schizophrenia	No	Yes (who): _____
Any genetic syndrome	No	Yes (who): _____
Seizure disorder	No	Yes (who): _____
Thyroid problems	No	Yes (who): _____
Type I Diabetes	No	Yes (who): _____

If there is other information that you think will be helpful to us, please explain below:

_____

_____

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