BACKGROUND INFORMATION FORM (CHILD VERSION)

CHILD'S NAME: ____ DATE: _______________ AGE: ______

ADDRESS: ____

PHONE: _________________________________ GENDER: ___________ DATE OF BIRTH: ___________

WHO REFERRED YOU TO OUR AGENCY: ____

EMERGENCY CONTACT:

NAME: ______________________________________ PHONE: ___________________________________

PRIMARY REASON FOR SEEKING COUNSELING:

____

____

____

____

____

____

FAMILY HISTORY

PARENTS:

MARRIED ____ DIVORCED _____ NEVER MARRIED _____ SEPARATED _____ WIDOWED: _____

DESCRIBE CUSTODY ARRANGEMENT: ____

PARENTS AND/OR GUARDIANS

HOUSEHOLD ONE:

MOTHER:

BIOLOGICAL PARENT: ______ STEP-MOTHER: ______ ADOPTIVE MOTHER: ______

FOSTER PARENT: ______ LEGAL GUARDIAN: ______ OTHER: ______

NAME: ____ AGE: ________ DATE OF BIRTH: ___________

ADDRESS: ____

PHONE: ________________________________ GENDER: ___________

EMAIL: ____

PERMISSION TO CONTACT BY:

PHONE: YES _____ NO _____ MAIL: YES _____ NO _____ EMAIL YES _____ NO _____

FATHER:

BIOLOGICAL PARENT: ______ STEP-MOTHER: ______ ADOPTIVE MOTHER: ______

FOSTER PARENT: ______ LEGAL GUARDIAN: ______ OTHER: ______

NAME: ____ AGE: ________ DATE OF BIRTH: ___________

ADDRESS: ____

PHONE: ________________________________ GENDER: ___________

PERMISSION TO CONTACT BY:

PHONE: YES _____ NO _____ MAIL: YES _____ NO _____ EMAIL YES _____ NO _____

HOUSEHOLD TWO (IF APPLICABLE)

MOTHER:

BIOLOGICAL PARENT: ______ STEP-MOTHER: ______ ADOPTIVE MOTHER: ______

FOSTER PARENT: ______ LEGAL GUARDIAN: ______ OTHER: ______

NAME: ______________________________________ AGE: ________ DATE OF BIRTH: ___________

ADDRESS: ____

PHONE: _______________________________ GENDER: ___________

PERMISSION TO CONTACT BY:

PHONE: YES _____ NO _____ MAIL: YES _____ NO _____ EMAIL YES _____ NO _____

FATHER:

BIOLOGICAL PARENT: ______ STEP-MOTHER: ______ ADOPTIVE MOTHER: ______

FOSTER PARENT: ______ LEGAL GUARDIAN: ______ OTHER: ______

NAME: ______________________________________ AGE: ________ DATE OF BIRTH: ___________

ADDRESS: ____

PHONE: _______________________________ GENDER: ___________

PERMISSION TO CONTACT BY:

PHONE: YES _____ NO _____ MAIL: YES _____ NO _____ EMAIL YES _____ NO _____

SIBLINGS AND OTHERS LIVING IN HOUSEHOLD ONE:

NAME	AGE	GENDER

PARENTS, SIBLINGS AND OTHERS LIVING IN HOUSEHOLD TWO (IF APPLICABLE):

NAME AGE GENDER

CURRENT MEDICATIONS:

NAME DOSAGE CONDITION/DIAGNOSIS

SURGERIES OR MAJOR ILLNESSES:

SOCIAL AND EMOTIONAL DEVELOPMENT

LIST YOUR CHILD'S GREATEST STRENGTHS:

LIST YOUR CHILD'S WEAKNESSES OR AREAS THAT NEED IMPROVEMENT:

LIST YOUR CHILD'S MAIN DIFFICULTIES IN SCHOOL:

LIST YOUR CHILD'S MAIN DIFFICULTIES AT HOME:

BRIEFLY DESCRIBE CHILD'S HOBBIES OR INTERESTS:

PRIMARY CARE PHYSICIAN:

DOCTOR'S NAME: ____ PHONE: _________________________

SPECIALIST DOCTOR(S):

DOCTOR'S NAME: ____ PHONE: _________________________

SPECIALTY: ____

DOES YOUR CHILD HAVE A HISTORY OF ABUSE? (CHECK ALL THAT APPLY)

PHYSICAL ABUSE: ______ SEXUAL ABUSE: ______ EMOTIONAL ABUSE: ______ NEGLECT: ______

PLEASE DESCRIBE ABUSE HISTORY, IF APPLICABLE:

IS THERE LEGAL ACTION PENDING ABUSE HISTORY? IF YES, PLEASE DESCRIBE:

CONSENT FOR CHILD TREATMENT

I AM THE PARENT/LEGAL GUARDIAN OF _______________________________________ (CHILD'S NAME).

I GIVE PERMISSION FOR MY CHILD TO RECEIVE MENTAL HEALTH SERVICES FROM ANY COUNSELOR EMPLOYED OR UNDER CONTRACT WITH THE CARING CENTER OF WICHITA, INC.

PARENT/GUARDIAN SIGNATURE: _____________________________________ DATE: ________________

PRINTED NAME: ___________________________________ RELATIONSHIP TO CHILD: _______________