*C*HILD *E*VALUATION & *T*REATMENT *C*ENTER

BIOGRAPHICAL DATA FORM © 1995

Please complete this form to the best of your ability. Feel free to use the reverse side of the pages to provide more in depth information.

Date:_____ Referred to *CETC* by:_____

This form was completed by:_____

I. DEMOGRAPHICS

Child's name:_____ Age:_____ DOB:_____
Address:_____ Home Phone:_____
Email: _____

Family Members (please include parents, step-parents, siblings, half- &step-siblings, and any significant individuals in the child's life):

NAME	AGE	RELATIONSHIP TO CHILD	LOCATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Child's school:_____ Grade:____ Teacher:_____
Child's physician/pediatrician:_____ Phone:_____

Father:
Employer:_____ Occupation:_____
Work Phone:_____ Cell Phone:_____ SSN:_____-_____-_____
Email: _____
Mother:
Employer:_____ Occupation:_____
Work Phone:_____ Cell Phone:_____ SSN:_____-_____-_____
Email: _____
Emergency contact person (other than parents):_____
Phone number:_____

II. DEVELOPMENTAL HISTORY

Please provide details regarding your child's prenatal history (e.g., was the pregnancy easy or difficult, was morning sickness or another illness a problem, was there much daily stress, did *in utero* development proceed normally, etc.):_____
_____
_____

Please provide similar details for your child's delivery: _____
_____
_____

Please describe how well you feel your child bonded with you and your spouse in the first few hours and days after birth: _____
_____
_____

Please describe any unusual problems your child has had with eating, sleeping, elimination, etc,:
_____
_____
_____

Please describe any significant allergies or medical conditions which interfere with your child's daily functioning:
_____
_____

Please describe any serious illness/injury (e.g., requiring hospitalization) your child has experienced:
_____
_____

Please indicate the approximate ages when your child achieved the following 'developmental milestones':

MILESTONE	AGE	COMMENTS
Walking	_____	_____
Talking	_____	_____
Toilet-trained	_____	_____
Sleeping/staying in own bed	_____	_____

If your child has ever been physically, sexually, or emotionally abused, please state the nature of the abuse; when it occurred; the perpetrator's age, gender, and relationship to your child; and how the abuse affected your child:_____
_____
_____

Describe your child's temperament in 3-5 words: _____

III. RELATIONS/CHILDREARING

Please describe the quality and/or nature of the relationship your child has with
You: _____
Your spouse: _____
Siblings: _____
Other significant caregivers (e.g., step-parents, etc.):_____

If you are married, please state for how long: _____.
Have there been any separations during your marriage, and if so, when and for how long? _____
_____

If you or your spouse has been previously married, please provide details (e.g., when, to whom, etc.):
_____
_____
_____

Who typically administers the discipline in your home? _____

What methods of discipline are used with your child? _____
_____

How effective are the discipline methods in modifying your child's behavior?_____
_____

How well do you and your spouse agree on the discipline and parenting methods that are used?
_____

What (if any) specific concerns or questions do you have regarding discipline and/or parenting?
_____
_____

IV. SCHOOL PERFORMANCE/PEER RELATIONS

Please comment on your child's academic abilities and performance: _____
_____

Please comment on your child's behavior at school: _____
_____

Please comment on your child's ability to form and sustain friendships: _____
_____

Please comment on your child's social skills in general (e.g., are they age appropriate, effective, etc.):
_____
_____
_____

V. PRESENTING PROBLEM, HISTORY OF PROBLEM(S)

Please state your reason(s) for seeking therapy now for your child:_____
_____

Please list the symptoms (behaviors and/or moods) your child is exhibiting that concern you: _____
_____
_____

Please provide details of any history in either the mother's or father's family of problems similar to those your child is exhibiting. Please also note a history of *any* mental health problems (e.g., depression, anxiety, hyperactivity, alcoholism, suicide, etc.)—whether treated or not—on either side of the family: _____
_____
_____
_____

If any members of your IMMEDIATE family (other than your child) have ever been in therapy, please state who, for how long, and the reason for seeking help: _____
_____

If any IMMEDIATE family member—including the child—has ever taken prescription medication *for the purpose of improving mood or behavior*, please indicate who, the name of the medication, and the reason for taking it: _____
_____

Please describe how you have tried to deal with your child's problems, specifying what has worked and what hasn't worked: _____
_____
_____

If your child has previously been seen in therapy, please indicate:
Where the therapy took place_____
Who the therapist was_____
The approximate dates spanning the therapy—from _____ to _____
The approximate number of therapy sessions_____
The reason for seeking help_____
_____
_____

If your child has been in therapy previously:

Did *you* have a positive experience? If no, why not? _____
_____

Did *your child* have a positive experience? If no, why not? _____
_____

What did you find *most* helpful? _____
_____

What did you find *least* helpful? _____
_____

VI. WORKING TOWARDS A SOLUTION

Please list several specific problem areas that you would like to see resolved as a result of therapy.

Problem area #1: _____

On a scale of 0 to 10, I would rate this problem (make an 'X' on the line):

0----------10

Not a problem A major problem

This will no longer be a problem when (i.e., the things that will be different will be)

1._____

_____

2._____

_____

Problem area #2: _____

On a scale of 0 to 10, I would rate this problem (make an 'X' on the line):

0----------10

Not a problem A major problem

This will no longer be a problem when (i.e., the things that will be different will be)

1._____

_____

2._____

_____

Problem area #3: _____

On a scale of 0 to 10, I would rate this problem (make an 'X' on the line):

0----------10

Not a problem A major problem

This will no longer be a problem when (i.e., the things that will be different will be)

1._____

_____

2._____

_____

VII. CLINICAL ASSESSMENT

(To be completed by therapist at initial session)

I.**MENTAL STATUS:** oriented x 4 (person, place, time, situation) –Yes/No

Comment (as needed): _____
_____
_____
_____

II. **SAFETY CONCERNS:** patient risk

A. HOMOCIDE…… None Current Recent Past
B. SUICIDE…….. None Current Recent Past
C. ELOPEMENT RISK…… None Current Recent Past

If there is any response other than 'None' in the above three areas, please indicate severity (mild, moderate, severe) and presence of Ideation, Method, Plan, and Intent. If necessary, proceed with more detailed assessments and interventions: _____
_____
_____
_____

III. **SUBSTANCE USE HISTORY**

A. ALCOHOL……..... None Current Recent Past
B. NICOTINE…… None Current Recent Past
C. PRESCRIPTION DRUG ABUSE…… None Current Recent Past
D. RECREATIONAL DRUGS……. None Current Recent Past
E. CAFFEINE…… None Current Recent Past

1. Does the use of any above substance meet DSM-IV criteria for *abuse*?
2. Does the use of any above substance meet DSM-IV criteria for *dependence*?
3. Substance abuse/dependence *treatment* history:

Comments (as needed): _____
_____
_____
_____

IV. **HISTORY OF ALLERGIES**..... None Current Recent Past
HISTORY OF ADVERSE REACTION TO MEDS None Current Recent Past

Comments (as needed): _____