PARENT COMPLETED
BACKGROUND SCREENING

Child

Client Legal Name: ___________________________

Date of Assessment:________________

Person(s) completing this form :___________________________________ Your relationship to child:_____________________

Identity

What name does your child prefer to be called? ___________________________________

What pronouns do they prefer people to use when referred to in the third person?

he/him/his   she/her/hers   Other: _________________________

The Good Stuff!

Please list this child's strengths and things that people enjoy about him/her.

Current Challenging Issues

In a sentence or two, what are the difficulties that this child is experiencing:

Please describe how the issues you mentioned above developed over time/when they started to become problematic?

Therapist notes:

Client Legal Name: ___________________________ Date of Assessment:________________

What have you tried on your own to try to help your child with these issues? What has worked and what hasn't? (Note: The sign of a "good parent" is not one that gets things right all the time but one that tries to solve problems...keeping the solutions that work, scrapping those that don't, and looks for information from outside sources when they are stumped. For a therapist to better understand what is going on, sometimes, what hasn't worked can provide just as much information as what has worked.)

Have you tried to get outside help for these challenges before? Yes____ No____
(If yes, list what kind of help & when/where it took place.)

Current & Past Mental Health Medication:

Family History

Please circle any emotional difficulties experienced by this child's immediate or extended family and note which family

excessive saddnes/depression	difficulty controling temper	suicide attempts/completions
excessive worry/panic/fear	difficulty staying focused/organized/managing time	seeing or hearing things that aren't there/delusional

Other issuea not listed above?

What important things (positive or negative) have happened in this child life or the family's life in the last year?

Education

School/District	Current/Highest Grade	Teacher

Learning Disabilities/IEP/504?

Suspensions/Expulsions?

Therapist notes:

PARENT COMPLETED
BACKGROUND SCREENING

Client Legal Name: ___________________________ Date of Assessment:________________

Medical Issues

Current Medical Issues & Significant Medical History (include chronic illnesses and any major medical problems the child may have experienced in the past):	Current Medications:

Sleep Quality		Details:
Y | N	Problems with quality of sleep? FALLING ASLEEP | MULTIPLE INTERRUPTIONS | EARLY WAKE	
Y | N	Often tired during the day?	
Y | N	Snoring?	
Y | N	Unusal leg discomfort or movements during the night	
Y | N	Falling asleep during the daytime when you want to stay awake?	

Diet/Nutrition				
Y | N	Eat three healthy meals/day?	Y | N	Limit junk food?	If they complain about their body, please give details below about what they say/do in this regard.
Y | N	Make themself throw-up after a meal?	Y | N	Binge eat?	
Y | N	Take laxitives when not constipated?	Y | N	Complain about their body?	

Details:

Safety Issues

Suicide/Self Harm			Details for anything marked "Yes":
Past 3 months	**Lifetime**	Have you been worried that your child has…	
Y | N	Y | N	...been thinking of ending their life?	
Y | N	Y | N	…engaging in risky or dangerous behavior?	

Non-Suicidal Self-Injury History	
Y | N	Has your child hurt themself purposely, in any way, without intent to die?

Trauma History			
Y | N	Physical Abuse	Y | N	Domestic Violence
Y | N	Sexual Abuse	Y | N	Ever Threatened?
Y | N	Emotional Abuse	Y | N	Other Trauma?

Danger to Others	
Y | N	Have they ever talked about physically hurting someone.
Y | N	Have they ever threatened to physically hurt someone?
Y | N	Have they ever hit or otherwise hurt someone or an animal?
Y | N	Have they ever been arrested for physically hurting someone or an animal?
Y | N	Do they "play" with fire in a way that feels risky?

Therapist notes:

Client Legal Name: ___________________________ Date of Assessment:________________

Substance Use

Do you suspect your child uses or has experimented with any form of:

Y | N	nicotine: cigarettes/cigars/chewing tobacco/patch/gum?
Y | N	alcohol?
Y | N	recreational drugs?
Y | N	misuse/abuse of prescription medications (theirs or someone else's)?

If yes…provide details *What forms of nicoteine/alcohol/recreational drugs/prescription medication? Amount & Frequency? By mouth/injection/other? First/last date of use & frequency?*

Has their drinking or other drug use ever caused problems in the following areas:

Y | N	Friendships	Y | N	School	Y | N	Health (blackouts, substance-related medical problems)
Y | N	Legal (arrests)	Y | N	High risk behavior		

Past Substance Use Treatment

Tx Dates	Provider	Meds	Outcome

Family Substance Use History

Y | N	Immediate or Extended Family History of Substance Abuse/Dependence/Addiction?

If yes…who and what/which substance(s)?

Extra Space/Other Pertinent Family Issues

Use the space below to add more details, mention something that is important for me to know that wasn't already covered by the questions in this form, or any family concerns that you don’t feel comfortable mentioning in front of your child today but would be helpful to me to know. (Some of these might be: drug/alcohol use in the home; domestic violence; significant physical or mental health issues of another family member; history of trauma; financial problems; incarceration; marital conflict; death.)

Therapist notes: