MetroHealth Medical Center
Child and Adolescent Psychiatry and Psychology
2500 MetroHealth Dr., Cleveland, OH 44109-1998
Phone – 216-778-3745

BACKGROUND INFORMATION

Filled out by _____
Today's Date _____/_____/_____

CHILD INFORMATION

Child's full name	
Child's birthdate	/ / Age
What name does child prefer?	
Gender	☐ Male ☐ Female ☐ Transgender/Nonbinary
Adopted?	☐ No ☐ Yes Age at Adoption:
Legally Responsible Party	Name:
	Relationship: ☐ Parent ☐ Relative ☐DCFS ☐ Other _____
Address:	
Home Phone	
Cell Phone	
E-mail	
Child lives with	
Child's Ethnicity/Race	
Child's Religion	
Language(s) spoken at home	
Are there any court documents pertaining to custody, visitation or medical decision-making?	☐ No ☐ Yes If Yes, please provide a copy at the first appointment
Sources of family income	

CONCERNS ABOUT CHILD

Please check any current problems or concerns you have about your child:

	✓			✓			✓
Oppositional, defiant behaviors			Depressed, sad mood			Habits	
Aggressive behavior			Anxiety/worries/fears			Somatic/physical complaints	
Attention problems			Self-harm (e.g., suicide, cutting,)			Adjustment to medical condition	
Conduct (lying, stealing)			Anger, irritability			Eating	
Poor school performance			Social skills/friends			Sleep	
Autism			Gender dysphoria			Other:	

	Please answer in space provided.
Who referred you to us?	
What are your main concerns about your child?	
Any additional problems or concerns?	
When did these problems start?	
What do you believe are the cause of these problems?	
What things have you tried to help your child?	
Why are you coming for help at this particular time?	
What are your child's strengths?	
GOALS: What would you like to see happen for your child as a result of our services?	

FAMILY INFORMATION

Please provide as much information as possible about both parents in the space below.

	CHILD'S MOTHER	CHILD'S FATHER
Full Name		
Age		
Employer/Occupation		
Highest education completed		
Marital Status		
Place of Birth		
Ethnicity/Race		
Language(s) spoken in home		
Religion		
Military history		
Health status		
Any mental health concerns?		

Other persons living in the same household as child including brothers, sisters, and others even if not related:

Name	Relationship	Age	Problems (if any)

Immediate family members ***not*** living in the same household as child:

Name	Relationship	Age	Problems (if any)

BIRTH AND DEVELOPMENTAL HISTORY

Where was your child born? _____ Birthweight: ____/____

When child was born, what was: Mother's age _____ Father's age _____

Was this an expected pregnancy? □ No □ Yes

Was mother ill during her pregnancy? □ No □ Yes _____

Were any medications taken during the pregnancy? (List) _____

Alcohol/Beer use Much Some None

Cigarette smoking Much Some None

Illegal drugs Much Some None (List) _____

Did mother experience unusual stress during pregnancy? □ No □ Yes _____

Birth was: Vaginal _____ Caesarian _____ Premature? □ No □ Yes How many weeks? _____

Birth complications, if any _____

In the first two years was baby	*More than other babies*	*Like other babies*	*Less than other babies*
Cuddly?			
Fearful?			
Irritable/Fussy?			
Sickly?			
Active?			

In the first 2 years of life, did you have any concerns about how your child was developing? □ No □ Yes

Describe: _____

What age was the child when he/she:

Milestone	*Age/months*		*Milestone*	*Age/years*
Sat up			Toilet trained/day	
Walked			Staying dry at night	
Said first words			Dressing self for most part	
Said combined words			Riding 2-wheeler bike	

What age was the child when mother returned to work? _____

Who cared for child when parents worked? _____

Has your child even been in day care? □ No □ Yes Age enrolled _____

Did your child attend preschool? □ No □ Yes Age enrolled _____

HEALTH HISTORY

Name of child's physician	
Physician's address	
Physician's phone	
Date of last complete check-up	
Ok to discuss child with physician?	☐ No ☐ Yes (Please initial here_____)

Has your child ever had:	✓		*Has your child ever had:*	✓		*Has your child ever had:*	✓
Allergies			Diabetes			Multiple Ear infections	
Asthma			Encopresis/Enuresis			Seizures/convulsions	
Brain injury/stroke			Hearing problems			Skin problems	
Chronic headaches			Hydrocephalus			Vision problems	
Chronic vomiting/poor weight gain			Meningitis			Other:	

Are you concerned about any aspect of the child's health? ☐ No ☐ Yes – please describe

_____

Has the child experienced any severe illnesses, accidents, operations, hospital admissions, operations, disabilities or repeated medical problems? ☐ No ☐ Yes – please describe

Does the child take medications for behavioral or emotional problems? ☐ No ☐ Yes – please describe

Name of medication	Dose	Purpose	Effect	Doctor

Does the child take any medications for any other purposes? ☐ No ☐ Yes – please describe

Name of medication	Dose	Purpose	Effect	Doctor

Additional Screening

Any weight +/- 10 pounds in past 3 months? ☐ No ☐ Yes – please describe

Any changes in appetite? ☐ No ☐ Yes – please describe

Food allergies or special diets? ☐ No ☐ Yes – please describe

Any dental concerns? ☐ No ☐ Yes – please describe

Does your child have pain concerns? ☐ No ☐ Yes – please describe

Does your child have problems with sleep? ☐ No ☐ Yes – please describe

What other doctors/specialists/counselors (and where) has your child seen?

Name	*Specialty*	*Location*	*Dates/How long?*

FAMILY HEALTH

Has anyone else in the family had difficulties that are similar to your child's? ☐ No ☐ Yes – please describe

_____

Has father, mother, brother, sister, grandmother, grandfather or any **close biological relative** had or have any of the below? (Please indicate who and describe problem in the space provided)

	✓*YES*	*If yes, please describe who and nature of problem:*
Learning disability		
Mental retardation		
Speech/language problems		
Hyperactivity/ADHD		
Autism		
Anxiety		
Depression		
Suicide/suicide attempt		
Bipolar disorder		
Schizophrenia		
Psychiatric hospitalization		
Alcoholism/heavy drinking		
Drug use/abuse		
Violence/Criminal activity		
Other problems		

SCHOOL HISTORY

Child's current school	
School address	
School phone	
Grade or education level	
Teacher	
Education Type	Regular / Cognitive Disability / Severe Emotional Disturbance / Learning Disability/ Other Health Impaired / Special Preschool / Other:
Ok to contact school	☐ No ☐ Yes – Best person to contact:
Last report card grades	
Other schools attended	

IN SCHOOL: Has your child	*✓YES*	*If yes, please describe*
Had learning problems?		
Had behavior problems?		
Had social/peer problems?		
Received special help (e.g., tutoring, special education, 504 Plan, guidance counselor)?		
Ever been held back a grade?		
Ever suspended or expelled?		
Other school problems?		

FRIENDS

Does your child have enough *close* friends? □ No □ Yes How many? _____

How does your child get along with friends? _____

Do you have concerns about how your child is developing sexually? □ No □ Yes _____

Has your child started dating? □ No □ Yes

Do you think your child is attracted to □ 0pposite sex □ Same sex □ Not sure

Do you think your child has used tobacco, alcohol or illicit drugs? □ No □ Yes _____

INTERESTS

Child's main interests	
List child's organized clubs, sports, & structured group activities (e.g., soccer team, gymnastics, drama club, church choir)	

DISCIPLINE

Who disciplines child?	
Forms of discipline is most commonly used	
How often child is physically disciplined	
Actions by your child most likely to be cause for discipline	
How well current discipline strategies are working	

SEPARATIONS, LOSS and TRAUMA

Has your child ever been separated from you for a lengthy period? □ No □ Yes

When? Why? And Who cared for him/her? _____

Has your child ever lost anyone through death (or separation) with whom he/she was close?

□ No □ Yes Who and when? _____

Has your child been exposed to violence in home or neighborhood? □ No □ Yes

If yes, please explain: _____

Do you have concerns that your child may have been physically or sexually abused? □ No □ Yes

If yes, please explain: _____

Do you have concerns that your child may be dangerous to him/herself or others (e.g., self-harming/cutting, suicidal, homicidal)? □ No □ Yes If yes, please explain: _____

LEGAL INVOLVEMENTS

Have there ever been services provided through the Dept. of Children & Family Services? □ No □ Yes

Please explain _____

Has child been involved in any custody matters? □ No □ Yes Please explain _____

Has child been involved with juvenile court? □ No □ Yes Please explain _____

CURRENT LIVING SITUATION

Do any of the following apply to the child's current living situation?

	✓*YES*	*If yes, please describe*
Marital or relationship problems between child's major caregivers		
Problems with siblings or others living in the home		
Problems with work situation		
Problems with present living situation or neighborhood		
Recent major changes or stresses in the child's living situation or family		
Violence in the home or neighgborhood		
Alcohol or drug problems in the home or neighborhood		
Other problems		

PLEASE WRITE DOWN ANYTHING ELSE YOU THINK WE SHOULD KNOW.

_____

_____

_____

_____

_____

_____

_____

Thank you for your thoughtful responses. You will have an opportunity to provide additional information when you meet with the behavioral health provider.