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A Multi-Specialty Behavioral Health Practice

Updated Information

Patient's Name______________________________ Date of Birth______________________

Mother's Name______________________________ Employment______________________

Address____

Father's Name______________________________ Employment______________________

Address (only if different)____

Parents: Married_________ Divorced_________ Single_________

Siblings (Names and Ages)____

Family History (please check all that apply)

ADHD_____ Anxiety_____ Depression_____ Learning Difficulties_____ Autism_____

Mood Disorder_____ Other (Please explain)____

Current Medication(s)____

What are your current concerns or questions?__________________________________

____

____

SCHOOL

School Name____ Grade_________

Grade Point Average (if appropriate)___________

List classes that are easy for the student____

List classes that are difficult for the student____

Homework Concerns____

What school-based services does the student receive?____

____

Does the student receive any support outside of school, such as tutoring?___________________________

____

Does the student have any post-high school plans? (if appropriate)__________________________________

____

Please attach current IEP or 5-4 Plan if available.

<u>BEHAVIOR/EMOTIONS</u>

Does your child currently present with any behavioral or emotional concerns at home?________________

____

____

Does your child currently present with any behavioral or emotional concerns at school?________________

____

____

<u>SOCIAL</u>

What are the student's extracurricular involvements?____

____

How does the student get along with peers?____

____

How would you describe your child's family interactions?____

____

Other Comments____

____

Person completing this questionnaire______________________________ Date________________