Emma Forbes-Jones, Ph.D.

Licensed Psychologist

900 Winton Road South, Suite 2
Rochester, NY 14618

phone 585.244.2429
fax 585.244.9932

CHILD /TEEN AND FAMILY INFORMATION FORM

Child/Teen Information:

Name:	Today's Date:
Date of birth:	Age:
Referred by:	Gender:
Address:	Cell phone:
	OK to leave message? Y N
Child lives with (check all that apply): _____ Mother _____ Other adult _____Father _____ Relative(s)	Who?: Who?:
Is your child/teen adopted? Y N	If yes, at what age?

Parent/Guardian Information:

Name:	Gender:
Address if different from child/teen:	Age:
	Home phone:
	OK to leave message? Y N
	Cell phone:
Marital status:	OK to leave message? Y N
Occupation:	Work phone:
Employer:	OK to leave message? Y N

Parent/Guardian Information:

Name:	Gender:
Address if different from child/teen:	Age:
	Home phone:
	OK to leave message? Y N
	Cell phone:
Marital status:	OK to leave message? Y N
Occupation:	Work phone:
Employer:	OK to leave message? Y N

Sibling Information:

Name	Age	Relationship (Full/Half/Step)	Lives with child/teen?
		F H S	Y N
		F H S	Y N
		F H S	Y N
		F H S	Y N

Provider Information

Pediatrician: _____

Psychiatrist: _____

Child/Adolescent Developmental History

Was pregnancy planned? □ Yes □ No Alcohol/Drug use during pregnancy? □ Yes □ No
Any problems during pregnancy? □ Yes □ No
If so, please describe:

_____

_____

Delivery: □ Premature □ Full-term □ Prolonged
Type: □ Spontaneous □ Forceps □ Induced □ Cesarean
Any problems during delivery? □ Yes □ No
If so, please describe: _____

_____

At about what age did your child:
(If age not known, indicate early, normal, or late):

Walk without help? _____
Say first words? _____
Speak in simple sentences? _____
Learn to read? _____
Learn bladder control? _____
Learn bowel control? _____
Did he/she wet the bed after age 5? _____

As a baby and toddler, was your child:

Fussy/irritable? _____
Easily soothed or calmed? _____
Responsive/interested in others? _____
Challenging to care for? _____
Did your child have difficulty separating from you? _____

Child/Teen Educational Information

Current School: _____ District: _____

Current grade: _____ Any repeated grades? □ Yes □ No

Missed days this school year? _____

504 Plan? □ Yes □ No Individual Education Plan (IEP)? □ Yes □ No

Support Services:	Past	Present		Past	Present
Speech Therapy	□	□	Physical Therapy	□	□
Occupational Therapy	□	□	Resource Room	□	□
Counseling	□	□	Other	□	□

Suspended/expelled from school now or in the past? □ Yes □ No If so, please explain:

_____

Are there any problems in school with: If yes to any, please describe:

Grades □ Yes □ No _____

Learning □ Yes □ No _____

Peer Relationships □ Yes □ No _____

Behavior in School □ Yes □ No _____

Child/Teen Medical History

Any current medical problems: □ Yes □ No If yes, please explain:

_____

_____

Has your child ever had any of the following:

□ Chronic ear infections □ Hearing Problems □ Hypertension □ Broken bones

□ Encephalitis □ Asthma □ Head Injury □ Diabetes

□ Loss of consciousness □ Seizures □ Meningitis

□ Cancer □ Heart Disease □ Skin Disease

□ Medication allergies □ Food allergies □ Environment or other allergies

□ Surgeries □ Other: (_____)

Psychiatric Medication

Name	Dosage	Response	Prescriber	Start date	End date

Other medication

Name	Dosage	Response	Prescriber	Start date	End date

Family Psychiatric History

Has any family member ever experienced any of the following?

Suicide attempt _____	Anxiety _____	Mood swings _____
Self-injurious behavior _____	Aggressive behavior _____	Alcohol abuse _____
Depression _____	Death by suicide _____	Drug abuse _____
Schizophrenia _____	ADHD _____	

If yes to any, please describe relationship to the child/teen, and how/when treated:

_____

_____

_____

Current concerns

Describe the behavior(s) and/or issues of most concern at this time:

_____

_____

_____

When did the concerning behavior(s) and/or issues begin? _____

Has your child/teen ever had outpatient mental health treatment before? If so, indicate name of therapist or psychiatrist, type of therapy, and outcome:

_____

_____

_____

Has your child/teen ever been hospitalized for mental health treatment before? If yes, indicate why and describe the outcome:

_____

_____

_____

What are the current stressors in your child/teen's life?

_____

_____

What do you see as your child/teen's strengths?

_____

_____

_____

Please provide any other information you feel may be relevant to an understanding of your child/teen (and/or family) as a person/people. This may include cultural background, language, ethnicity, sexual orientation, adoption, spirituality or religion, or anything important to a sense of his/her (your) identity and view of the world.

_____

_____

_____

_____	_____	_____
Name of person completing form	Relationship to patient	Date