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Patient's Background Information Form

I. Identifying information:

Today's Date:_____

Clients Name: _____Race: _____ Birth Date: _____

Client's Address_____
Street address *City* *State* *Zip Code*

Telephone (____) - _____ Insurance Name & ID#_____
(if MA assistance plan, state ID/Medicaid #)

Subscriber Name and DOB_____ Member services phone # _____

mother's name: stepmother's name:
father's name: stepfather's name:
sibling name:
If not living with parents list the name(s) of primary provider(s):

Mother's Occupation: _____Mother's Education:_____
(Highest grade/degree completed)

Address if different
from above: _____

Father's Occupation:_____Fathers Education:_____
(Highest grade/degree completed)

Address if different from above:_____

Marital status: _____Custody:_____
(Married, separated, never married, divorced, deceased)
If adult patient, your marital status
Ifminor, parents marital status

Client is: *(circle one that applies)* biological child adopted foster child

Language spoken at home:_____

Client's legal problems (*list all offenses or charges*)_____ History of abuse_____

History of domestic problems:_____

II. Referral Information

1. Reason for seeking/requesting this assessment_____

2. Person referring/recommending the evaluation:_____

3. The main behavioral/emotional/developmental/educational issues:

_____

_____

_____

III. Treatment History

Current Treatment providers (*Mental Health, in school services, developmental specialist, physicians, hospitalizations*)

Name of provider/Agency	Dates services were given	Main treatment focus

Prior Treatment Providers *(see current treatment providers for examples of services)*

Name of provider/Agency	Dates services were given	Main treatment issues

IV. Pregnancy and Birth History of the identified client

During pregnancy <u>with you</u> (if patient is adult)/ <u>with your child</u> (if patient is minor):

Medical problems _____

Medications_____
(if yes, for what reason and what Medications)

smoking _____how much_____ use of alcohol _____how much_____

Illegal drugs_____how much__ _____

Mother's age at birth _____Length of Pregnancy_____
(Weeks of gestation)

if premature how many weeks_____

Delivery Type:_____ if C-section _____
(Vaginal, scheduled cesarean, emergency cesarean) *(For what reason)*

Problems during labor or delivery_____

Birth Weight_____lbs. _____oz. Apgar scores_____

Complications after birth:_____
(Breathing issues, umbilical cord, jaundice, meconium aspiration, etc)

birth Defects _____

V. Development

Motor skills

rolled over _____ Sat Alone_____

Crawled _____ Walked alone _____

Handedness: right _____ Left_____ Both_____

Prior treatment for Motor Skills:

Occupation Therapy_____
(When and how long)
Physical Therapy _____
(When and how long)

Language Skills

Babbled_____Spoke first words_____ Put 2-3 words together_____

Any oromotor problems_____
(Sucking, chewing, drooling)

Speech/articulation problems_____

Toilets training for day occurred _____at night at the age of _____

Bed-wetting accidents soiling_____

Sleeping problems _____Eating problems _____

Social Behaviors

Early Temperament: *(circle one)* even-tempered shy over active

Did client respond to cuddling_____

Did client understand social cues_____

Problems making friends_____Problems keeping friends_____

Preferred to be alone_____ Plaid with older_____younger_____same age peers_____

VI. Medical Issues (indicate for each how long this was some problems, how frequency, and how it is treated)

Asthma_____ Allergies_____

Headaches_____ Vision Problems_____

Hearing Problems_____ Ear Infections _____

Seizures/convulsions_____ Head Trauma _____

Diabetes_____ Hormonal issues_____

Lead poisoning_____ Tics/Twitching_____

Any other serious medical problems:_____
or infections

List prior hospitalizations for medical reasons:

When and where	reason	main treatment

List current Medications

Name	since when	dose

Family medical history

Mother's side	Father's side

VII. Educational History

School District:_____Grade:_____

School:_____ Curriculum:_____
(regular, learning support, emotional support, life skills)

Any grades skipped _____ Repeated_____

Problems: (circle all that apply) attention aggression math with peers/sibling

reading writing spelling organization/planning

Educational problems: (*indicate what problems and at what grades)*

Preschool_____ Kindergarten_____

1st grade_____2nd grade _____

3rd grade_____ 4th grade _____

5th grade_____ 6th grade _____

7th grade_____ 8th grade _____

9-12 grade _____

Prior psychoeducational/Psychological/Intellectual assessments

date	measures given	findings

Intellectual skills are : (*circle one that apply*) Significantly impaired Below average Average Above average Superior

VIII. Work History, if applicable

Type of work	Dates