natural resilience

Date: _____

Name of Child: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Name of Parent/Guardian: _____

Address: _____

Telephone Numbers (Home/Work/Cell): _____

Behavioral Excesses:

What does your child currently do too often, too much or at the wrong times that gets them into trouble? Please list all of the behaviors you can think of.

_____

_____

_____

_____

Behavioral Deficits:

What does your child fail to do as often as you would like, as much as you would like or when you would like? Please list all of the behaviors that you can think of.

_____

_____

_____

_____

Behavioral Assets:

What does your child do that you like? What do they do that other people like?

_____

_____

_____

_____

_____

Other concerns:

Do you have other concerns about your child or your family that you have not yet mentioned?

_____

_____

_____

Treatment Goals:

From the list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST?:

_____

_____

Family History:

The name of the child's biological parents and current ages:

Mother _____ age: _____ Father: _____ age: _____

Who has legal guardianship of the child: _____

Who does the child currently live with: _____

Names	Ages	Relationship to child

Parent's current marital status:

Date of their marriage: _____ Never married: _____
Separated for _____ years
Date of their divorce: _____ Number of years _____
Mother remarried _____ times Dates _____
Father remarried _____ times Dates _____
Mother involved with someone (name and length of time) _____
Father involved with someone (name and length of time) _____

Mother deceased for _____ years
Age of child at mother's death _____
Father deceased for _____ years
Age of child at father's death _____

Are there any current custody proceedings taking place? _____

If parents are sharing custody or if there is visitation, how much time does the child spend with each parent?
Mother: _____ Father: _____

If there is shared custody, does the child have a change in behavior when making transitions from one home to the other? If yes, please describe.

Who are your child's significant others NOT living with your child?

Names Ages Relationship to child

How would you describe the emotional climate in your home?

_____Outstanding home environment
_____Normal home environment
_____Chaotic home environment
_____Witnessed physical/verbal/sexual abuse towards others
_____Experienced physical/verbal/sexual abuse towards others

Does anyone in your child's family currently use (or in the past) any type of drug, tobacco or alcohol? Please describe.

Please describe any past counseling that your child or other close family member has had.

What are some of the things that are currently stressful to your child and your family?

Is there a history of mental illness in your family? Who? Diagnosis?

Do other children in the family have behavioral or academic problems? Who?

_____
_____
_____

Education History:

What school does your child attend? _____
_____
Address: _____
_____
Phone: _____ Teacher's Name: _____
Current Grade: _____

What does your child's teacher say about him or her?

_____
_____
_____

What other schools have they attended?

_____
_____

Has your child ever had to repeat a grade? _____ If so, which one(s): _____

Has your child ever received special education services? _____

Has your child experienced any of the following problems at school?

_____Fighting _____Lack of friends _____Drug/Alcohol
_____Suspension _____Learning disabilities _____Poor Attendance
_____Detention _____Gang Influence _____Behavior Problems
_____Poor Grades _____Incomplete Homework _____ Bullying
_____ Other:

_____
_____
_____
_____

Medical History:

What is the name of your child's medical doctor? _____

Date of your child's last medical examination: _____

What was the state of the mothers health during pregnancy?
Poor Fair Good Excellent Unknown

Did the mother experience any of the following during pregnancy
_____Bleeding_____High blood pressure _____Nausea _____Vomiting
_____Diabetes_____Thyroid problems _____Physical or emotional trauma

Did the child's mother use any of the following during the pregnancy?
Tobacco _____
Alcohol _____
Recreational drugs _____
Prescription Drugs _____
Over-the-counter medication _____
Supplements: _____
Others _____

How was your child's health in the first year?
Poor Fair Good Excellent Unknown

How would you describe your child's temperament?
_____

Has your child experienced any of the following medical problems?
_____ Serious accident _____ Hospitalization _____ Surgery
_____ Head injury _____ High Fever _____ Seizures
_____ Eye/Ear problems _____ Meningitis _____ Asthma
_____ Allergies _____ Other _____

Describe your child's sleep pattern: _____

Describe your child's general dietary habits:
_____
_____

Please describe any past psychological testing that your child had. When and where did they take place? Are the reports available?
_____
_____
_____

Please list any current medical problems, diagnosis, or physical handicaps:
_____
_____

Please list any medications your child takes on a regular basis:

Other History:

Has your child ever experienced any type of abuse (physical, sexual or verbal)? What was their response? What response did the family take?

Has your child every witnessed abuse (physical, sexual or verbal)? What was their response? What response did the family take?

Has your child ever made statements of wanting to hurt him or her self or seriously hurt someone else?___ _____ Have they ever purposely hurt themselves or another person?_____ _____ If yes to either question, please describe the situation.

Has your child ever experienced any serious emotional losses such as the death or physical separation from a parent or other caretaker?

Has your child ever been in a car accident or experienced a situation that they were confronted by death? Or been a witness to an event where death did or could have occurred? When did it occur? Please describe any behavioral changes that occurred after the event.

Environment:

What are your child's favorite activities?

Does your child exercise regularly? How much and how often?

_____
_____
_____

How many hours of television does your child watch? _____

How many hours does your child play video games? _____

Is your child exposed to violence or frightening images TV, video games or movies? _____
How often? _____

Is there anything else that you feel is important that has not been covered?

_____
_____
_____
_____
_____

Spence Children's Anxiety Scale (Parent)
Spence Children's Anxiety Scale (Child)
Becks Children's Depression Scale

Thank you for taking the time to provide a history about your child!