• W C B H •

Western Connecticut Behavioral Health, LLC

Minor Information Form

Child's Full Name: _____

Child's Date of Birth: _____ Age: _____Today's Date: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: _____ Cell phone: _____

Parent 1 Full Name: _____

Address (if different): _____

Phone: _____ Cell: _____

Email: _____

Parent 2 Full Name: _____

Address (if different): _____

Phone: _____ Cell: _____

Email: _____

Parents' Marital Status: _____

Current Custody Arrangement (if applicable): _____

_____

Are you the child's legal guardian (please circle)? YES NO

If no, please list the name and phone number for the legal guardian: _____

_____

Was the child adopted? YES NO

If yes, at what age? _____

How do you prefer communication, such as to schedule or reschedule appointments (please circle)? Home phone Cell phone E-mail _____

May I leave a message on the answering machine (please circle)? YES NO

Emergency contact person: _____

Relationship to your child: _____ Phone: _____

Physician Name: _____ Phone: _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Family Information:

Please list any siblings, including full/half/step:

Name	Relationship	Age	History of illness
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other people living in the home: _____

Primary language spoken in the home: _____

Department of Child & Families (DCF) involved currently? YES NO

If yes, please explain. _____

Developmental Information

Was your child premature (please circle): YES NO Weeks gestation _____

Any prenatal problems (please circle): YES NO

Please list when your child achieved these milestones

Smiled: _____ Sat up independently: _____

Walked: _____ Talked: _____

Said first word: _____ Said first sentence: _____

Any speech, hearing, or language difficulties (please circle): YES NO

Did your child qualify for Early Intervention Services (please circle): YES NO

Is your child currently receiving speech, physical or occupational therapy? YES NO

Medical History

Date of most recent physical exam: _____

Has your child ever had a concussion or serious head trauma (please circle): YES NO

Has your child ever had a seizure (please circle): YES NO

Does your child have any allergies (please circle): YES NO

If yes, please list. _____

Please list any medications your child currently is prescribed, including name and dosage and current prescriber. _____

_____

_____

Please list any significant medical conditions your child has been diagnosed with, including follow-up care instructions. _____

_____

_____

Educational History

Name of your child's current school: _____

Town: _____ Current grade: _____Teacher: _____

Has your child ever repeated a grade (please circle): YES NO

Does your child have an IEP (please circle): YES NO

Does your child have a 504 plan (please circle): YES NO

If yes, please list any special school accommodations: _____

_____

_____

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

_____

_____

Has your child ever experienced any of the following problems at school? Please circle all that apply.

Fighting	Drugs	Alcohol	Suspension
Poor Attendance	Detention	Learning Disabilities	Poor Grades
Gang Influence	Incomplete Work	Lack of Friends	Behavioral Problems

Family Mental Health History

Is there a history of mental illness in your family (please circle): YES NO

If so, please describe _____

Is there a history of learning disabilities in your family (please circle): YES NO

If so, please describe _____

Is there a history of substance abuse in your family (please circle): YES NO

If so, please describe _____

Mental Health History

Has your child ever previously attended counseling or therapy (please circle): YES NO

Name of Therapist and Agency _____

Has your child ever been hospitalized for a psychological reason (please circle): YES NO

If so, please describe _____

Behavioral Observations. Please circle all that apply.

Sadness	Suicidal Thoughts	Sleep Problems	Change in Appetite
Weight Change	Concentration	Obsessive Thoughts	Anxiety
Panic Attacks	Memory Problems	Hostility	Violence
Social Isolation	Strange Thoughts	Stomach Complaints	Frequent Headaches
Bed Wetting	Phobias	Daytime Accidents	Aggression