Craig D. Olson, Psy.D & Assoc., LLC
Clinical Psychologist

Office Address
7071 Corporate Way, #106
Centerville, OH 45459
(937) 436-5999

Web Address
www.craigdolsonpsyd.com

Fax Number
(937) 999-6643

Date _____

CHILDREN'S BACKGROUND FORM

THE INFORMATION YOU GIVE IS FOR PROFESSIONAL USE ONLY.

Child's Full Name _____

Birthdate _____ Age _____ Sex _____

Address _____

City _____ State _____ Zip _____ Phone _____

School _____ Grade _____ Teacher _____

Address _____ Phone _____

Family Doctor _____ Referred By _____

List any physical or medical condition that affects your child's functioning: _____

_____

PARENTS

Father's Name _____ Social Security # _____ Birthdate _____

Address (if different) _____ Phone _____

Education _____ Occupation _____

Mother's Name _____ Social Security # _____ Birthdate _____

Address (if different) _____ Phone _____

Education _____ Occupation _____

HEALTH INSURANCE

Health Insurance Co. _____ Filing Address _____

Phone # _____ Policy # _____ Group # _____

Policy Holder Name _____ Address _____

Social Security # _____ Birthdate _____

Employer _____ Relationship to Patient _____

Has Authorization Been Obtained? Yes _____ No _____ Not Applicable _____

CHILDRENS BACKGROUND FORM

Date _____

So that we can help you, please fill out the following information about your child. This information will be treated in a professional manner.

Child's Name _____ Sex _____ Age _____ Birthdate _____

_____ Street _____

(Signature of Parent or Guardian) City _____ State _____

Zip Code _____ Phone _____

(Address/Phone of Parent or Guardian)

Name of person filling out this form _____

What is your relationship to this child? _____

In your own words, what are the problems or difficulties your child is experiencing? _____

_____

_____

_____

_____

Have you tried to get any previous help for this? _____ What kind? _____

_____ When? _____ Where? _____ Was this helpful? _____ How? _____

_____

What procedures have you tried on your own? _____

_____

When did these problems first begin? _____

What important things have happened to your child or the family in the last six months? _____

_____

What sudden changes have you noticed recently in his/her behavior and moods or in family members?

_____

_____

_____

BIO-MEDICAL AND DEVELOPMENTAL HISTORY

What aches, pains or physical discomforts does your child have these days? _____

_____

What has he/she been hospitalized for in the past? _____

_____

What problems were there during pregnancy and birth with your child? _____

_____

How much did he/she weigh at birth? _____

At what age did your child:

Sit alone _____ Say his/her first word _____

Walk alone _____ Use two words together _____

Ride a tricycle _____ Become toilet trained _____

Dress himself _____ Learn basic colors _____

What accidents has your child had? _____

What is the name and address of the physician who usually sees the child? _____

_____

When was his/her latest medical examination? _____

What medications is he/she taking these days? _____

What is the name and address of the person to notify in case of an emergency? _____

_____

Who referred you to us? _____

SCHOOL HISTORY

Which schools has your child attended since entering school? _____

_____

What grade is your child in now? _____ At what school? _____

In what three subjects does he/she earn his/her best grades? _____

_____

In what three subjects has he/she earned his/her lowest grades? _____

_____

What grade did he/she repeat? _____

Is your child's schoolwork: Above average _____ Average _____ Below Average _____

What are his/her favorite subjects? _____

_____

What special school problems does your child have? _____

_____

What psychological or achievement tests has your child had previously? _____

_____

What were the results or scores? _____

HOME HISTORY

What problems does your child have at home? _____

When are these problems worse? _____

When are they better? _____

Please fill in the names, ages, etc. of your child's family.

Name	Age	Level of Education	Occupation	Where Employed	Work Schedule
Father					
Mother					
Brothers					
Sisters					

Birthdate _____ Age _____

Others living in your home _____

_____

_____

(If any of the above are adopted, please indicate this.)

Which child seems easiest to get along with and why? _____

_____

Which child is the most difficult and why? _____

_____

Who disciplines the children and how? _____

_____

_____

What year were your child's parents married to each other? _____

What marital problems have there been between the parents? _____

_____

_____

_____

_____

Previous marriages for the father? _____ From: _____ To: _____

Previous marriages for the mother? _____ From: _____ To: _____

How do the parents feel about the child? _____

_____

_____

Please CIRCLE any of the following which are problems with this child.

a.	Stealing	j.	Tiredness/Fatigue	s.	Clumsiness
b.	Lying	k.	Eating Problems	t.	Over-activity
c.	School Problems	l.	Sex Problems	u.	Under-activity
d.	Running Away	m.	Shyness	v.	Easily Upset
e.	Toilet Problems	n.	Extreme Fears	w.	Self-critical
f.	Temper Tantrums	o.	Over-dependency	x.	Destructiveness
g.	Nail Biting	p.	Jealousy/Resentment	y.	Depression/Sadness
h.	Sleep Problems	q.	Cruelty	z.	Guilt Feelings
i.	Nervousness	r.	Over-sensitive		

Please tell us a little about each you circled. _____

_____

_____

_____

_____

_____

What are his/her strong points or favorable characteristics? _____

_____

_____

What are the "good" behaviors your child engages in? _____

_____

_____