MANDALA
FAMILY WELLNESS

Background Paperwork

Contact Information

Child's Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone: _____ Male_____ Female _____

Mother's Name: _____ Date of Birth: _____

SSN: _____ Education: _____

Employer: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Father's Name: _____ Date of Birth: _____

SSN: _____ Education: _____

Employer: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Email: _____

Name of completing form:_____ Referred by: _____

Primary language spoken: _____ **Secondary language spoken:** _____

Please list any translation needs if applicable: _____

If child is not living with both biological parents, please describe living and visitation arrangements:

_____

If parents are living apart (separated or divorced), is other parent aware that you are seeking psychological services for your child? ☐Yes ☐No

If parents are living apart, please provide address for non-custodial parent.

Parent's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sibling Name	Sex	DOB	School/Occupation
Other Person(s) in the Home	**Sex**	**Age**	**Relation to Child**

Client Name: _____

Birth, Development, and Family History

Child's Birthplace (City and State): _____

Mother's age at delivery: _____Health during pregnancy: _____

_____

Describe any exposure to alcohol, legal prescriptions, or illegal drugs during pregnancy: _____

_____

Approximate weight at birth: _____ Weeks Carried: _____ Type of Delivery: _____

Hours of labor: _____ Was labor induced? _____

Describe any complications during pregnancy birth, or after delivery: _____

_____
__

Check the items that apply to your child's behavior when s/he was an infant:

___ Frequently smiled __ Easy to soothe ___ Difficult to soothe ___ Frequently cried
___ Cried when wet ___ Enjoyed being held __ Enjoyed being rocked
___ Adapted easily to new situations

Check the items that apply to your child's behavior when s/he was a toddler:

___ Independent	___ Talkative	___ Angry	___ Fearless
___ Overactive	___ Daring	___ Stubborn	___ Compliant
___ Quiet	___ Curious	___ Aggressive	___ Distractible
___ Friendly	___ Affectionate	___ Easy to discipline	___ Adaptable

Please give approximate ages (in months) for the following:

____ Sat up ____ Walked ____ Toilet trained ____ Stopped the pacifier

____ First word ____ Talked in sentence ____ Stopped breast/bottle feeding

Current level of communication: _____

Please list any pertinent family medical or psychiatric history (including parents, siblings, and grandparents on both sides):

_____

Client Name: _____

Health Information

Pediatrician's name_____ Telephone number _____

Date of last medical checkup_____ Results of check-up: _____

Please describe any health problems: _____

Is your child taking medication at this time (if yes, describe below)? ☐Yes ☐No

Name of Medication	Dose/Frequency	Prescribed For	Prescribed By

Please provide information regarding the medical conditions described below. If necessary, use the additional space.

Allergies	☐Yes	☐No	Describe: _____
Dietary restrictions	☐Yes	☐No	Describe: _____
History of ear infections	☐Yes	☐No	Describe: _____
History of head injuries	☐Yes	☐No	Describe: _____
History of seizures	☐Yes	☐No	Describe: _____
History of hospitalizations	☐Yes	☐No	Describe: _____
History of surgeries	☐Yes	☐No	Describe: _____
ER visits in the last year	☐Yes	☐No	Describe: _____
Glasses/Contacts	☐Yes	☐No	Describe: _____
Recent Hearing Test	☐Yes	☐No	Describe: _____
Hearing/Vision concerns	☐Yes	☐No	Describe: _____

School and Educational Information

Please list all daycares and/or schools your child has attended (including current placement):

Name of Daycare/School	Dates of Attendance	Grades Completed

Client Name: _____

Most recent standardized test scores (e.g., FCAT, SAT): _____

What kinds of grades does your child usually earn? _____

In what school situations or subjects does your child perform best? _____ Worst? _____

Is your child in special education classes? ☐ Yes ☐ No If yes, what kind? _____

Does your child have an Individual Education Plan (IEP) ☐ Yes ☐ No If yes, under what category and when was the date of last IEP meeting? _____

What does the IEP Address: ☐ Speech ☐ OT ☐ Behavior ☐ Academics

Does your child receive accommodations under the 504 plan? ☐ Yes ☐ No _____

Does your child have problem behaviors in school? If yes, then what problems? _____

_____

Has your child ever repeated a grade? ☐ Yes ☐ No If yes, which grade(s)? _____

Describe your child's feelings about school: _____

Describe your feelings about your child's school program: _____

Social and Emotional Information

List your child's major interests, toys, and/or hobbies: _____

_____

List any activities your child is involved in: _____

Any socialization concerns?

_____

Current Needs and Former Service Provider Information

Please list all Psychological, Behavioral, Occupational, Physical or Speech therapy your child is receiving or has received in the past: Please also include any Psychiatric services your child has received or is receiving:

Agency/ Therapist Name	Type of Therapy	Dates of Service	Hours/week

Please check-off what documentation you can provide us:

Previous Psychological Tests: _____ Previous Academic Testing: _____ IEP/504: _____

Treatment Summary or Discharge Summary from other treatment providers: _____

Has your child ever received psychiatric services? ☐ Yes ☐ No

Client Name: _____

If yes, when and by whom? _____

Has your child ever received counseling or psychotherapy? ☐ Yes ☐ No

If yes, when and by whom? _____

Has your child ever received psychological testing? ☐ Yes ☐ No

If yes, when and by whom? _____

Results: _____

Has your child ever been tested for learning disabilities? ☐ Yes ☐ No

If yes, when and by whom? _____

Results: _____

Has your child ever been evaluated by a psychiatrist? ☐ Yes ☐ No

If yes, when and by whom? _____

Results: _____

Additional Information

If you would like, please provide any other information that will help us better understand your child, *including* a brief description of the current areas of concern that you are hoping to address: _____

While we do our best to accommodate each family's busy schedule, we know that beginning services for your child is very important to you. A typical Intake appointment takes 1 ½ hours and is a parents-only appointment. **Please tell us which days and times are NOT CONVENIENT for an Intake appointment as well as for on-going treatment appointments with your doctor and/or therapist.**