**FAMILY BACKGROUND INFORMATION FORM**

**GENERAL ASSESSMENT INFORMATION**

**Child**

Child’s Name:      DOB:       Client Number:

Child’s Name Verified by Birth Certificate: Yes No Alias used is applicable:

City/State where child was born:

Is the child a member of an affiliated tribe: Yes No Please list the tribe:

Enrollment Number:

What is the child’s nationality:

How was the child’s name selected?

**CHILD DEVELOPMENT**

Child’s Age      Is the child left or right handed:

Crawling Age:      Walking Age      Talking Age      Potty Training Age

If there is/was any delay in any of these developmental milestones, was the child assessed? Please list the delay, who assessed the child, and when the child was assessed:

Is the child physically coordinated? Yes No

What is the child’s favorite food(s):

What is the child’s favorite toys/games/movies/books/activities:

Can the child tie his/her own shoes Yes No Can the child zip his/her own clothing: Yes No

**Sleep Patterns**

Does the child take naps and at what time(s) of day: Yes No

Does the child sleep during the night? Yes No

Does your child have nightmares? If yes, please describe and how do you comfort him/her?

Do you have any routines you perform when the child goes to bed or has a nap (read a book, sing, say a prayer, etc.) Please list:

Does your child require a nightlight: Yes No

Does your child have a favorite pillow/blanket/stuffed toy: Yes  No

Does your child wet the bed? Yes No

**Hygiene**

Does your child dress himself/herself: Yes No

Does your child brush his/her teeth at least twice a day: Yes No

Does your child bathe himself/herself adequately Yes No

Does the child require special hygienic products? Please list:

**Social Interactions**

Who are the child’s peers and are they younger or older than your child (please list):

Does the child have any pets? If so, what type of pet and what is their name:

How does the child interact with his/her pets?

**PHYSICAL AND MENTAL HEALTH ON CHILD**

**Child**

**Prenatal:**

Mother’s age at pregnancy:      Father’s age at pregnancy:

Did you smoke during your pregnancy: Yes No How much:

Did you use alcohol during your pregnancy: Yes No How often

Did you use drugs during your pregnancy: Yes No How often

Did you attend a prenatal class: Yes No Did you have a partner: Yes No

Did you attend routine medical exams during your pregnancy? Yes No

Describe any prenatal complications you had:

**Postnatal:**

Type of delivery (forceps, c-section, vaginal):

Duration of labor:

Complications of birth (breech, oxygen deprived):

Physical problems noted at birth:

Full term gestation: Yes No

Birth weight      Birth length

Does the child have birth or other identifying marks (please list):

Was your child circumcised: Yes No

Was your child breast fed or formula fed (name type of formula)?

Child’s Blood type:      Mother’s blood type:      Father’s blood type:

**General**

Current weight:      Current Height:       Hair color      Eye Color

Immunizations current: Yes No

Does the child have allergies? Please list      How do you treat the allergies (medications, etc.)

Does the child have/had any childhood diseases? Please list       How is/was this being treated:

Hospitalizations

Surgeries

Age of menstruation onset:

Are/were there particular foods that the child cannot eat due to health reasons:

Complications or other health problems

Who takes care of the child when he/she is ill:

Current Physician:      Name of clinic:

**Dental**

Has your child had a dental exam: Yes No Please list date of last exam:

Does your child wear/require braces: Yes No

Does your child have any identified dental needs (please list):

Current Dentist:      Name of clinic:

**Vision**

Has your child had a vision exam: Yes No Please list date of last exam:

Does your child wear/require corrective lens: Yes No

Does your child have any identified vision needs (please list):

Current Doctor:      Name of clinic:

**Hearing**

Has your child had a hearing test: Yes No Please list date of last exam:

Does your child wear/require hearing aids: Yes No

Does your child have any identified hearing needs (please list):

Current Audiologist:      Name of clinic:

**CONNECTIONS AND CULTURE**

**Heritage and Traditions**

Is there a special meaning to the family name?

What languages are spoken in your home?

List important milestones for children and adults in your culture/heritage?

Are there traditional foods that your family eats?

Which holidays/traditions do you celebrate and how do you celebrate them?

**Religion**

Is there a particular faith that you practice?

Does your child participate in the practices of this faith Yes No NA

Has your child been baptized Yes No NA

**Culture**

Maternal origin/ethnicity

Paternal origin/ethnicity

Child’s origin/ethnicity

How much does your child know about his/her culture?

What are the advantages to being male/female in your culture/family?

List the different roles and duties that males and females have in your culture/family:

Is it acceptable to be a single parent in your culture/family Yes No

What type of hair cut or length is important in you culture/family?

Would you like to be notified before cutting your child’s hair? Yes No

Do extended family members/friends reside with you in your home? Please list:

**Community/Activities/Hobbies**

Describe the neighborhood/community you live in (rural, urban, ethnic, etc):

Describe the neighborhood/community you grew-up in:

What do you like/dislike about the neighborhood/community you live in?

Please list the activities your child is involved?

Please list the activities you are involved in:

What hobbies and special interests does your child have?

What hobbies and special interests do you have?

Does your child participate in sports? Please list:

**Moves or Placements**

**Birth Home:**

Who lived in the home at this time?

How long did you live in this home?

How old was the child when you moved?

What was their attitude about moving?

How did the child adjust to the move?

Did the child behave differently at this time (please describe)?

Did the child have any traumatic experiences at this home?

**Next Move:**

Who lived in the home at this time?

How long did you live in this home?

How old was the child when he/she was moved/placed?

What was their attitude about moving/being placed?

How did the child adjust to the move/placement?

Did the child behave differently at this time (please describe)?

Did the child have any traumatic experiences at this home?

**INFORMATION ON BIOLOGICAL MOTHER AND FATHER**

|  |  |  |
| --- | --- | --- |
| **Background Information** | **Mother** | **Father** |
| Name |  |  |
| Alias/Maiden Name |  |  |
| Date of Birth |  |  |
| Client Number |  |  |
| Marital Status |  |  |
| Address |  |  |
| Telephone Number |  |  |
| Place of Birth |  |  |
| Race-Tribe |  |  |
| Religion |  |  |
| Enrollment Number |  |  |
| Favorite Foods |  |  |
| Hobbies, Talents, Skills |  |  |
| Age at Death (if applicable) |  |  |
| Cause of Death (if applicable) |  |  |

|  |  |  |
| --- | --- | --- |
| **Employment** | **Mother** | **Father** |
| Current Employer |  |  |
| Type of Employment |  |  |
| Length of Time at this Job |  |  |
| Military Service |  |  |
| Date and Place of Military Services |  |  |

|  |  |  |
| --- | --- | --- |
| **Education** | **Mother** | **Father** |
| Last Grade Completed |  |  |
| Learning Disabilities |  |  |
| Name of School and Location |  |  |
| Diploma/GED |  |  |
| Extracurricular Activities |  |  |

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| --- | --- | --- |
| **Physical & Mental Health** | **Mother** | **Father** |
| **Physical Health** |  |  |
| Current Physician |  |  |
| Weight |  |  |
| Height |  |  |
| Distinguishing Marks-Tattoos |  |  |
| Current Health Condition |  |  |
| Heart Disease |  |  |
| High Blood Pressure |  |  |
| Diabetes |  |  |
| Cancer |  |  |
| Seizures, Convulsions, Epilepsy |  |  |
| Cerebral Palsy |  |  |
| Paralysis or Crippling Disorder |  |  |
| Multiple Sclerosis |  |  |
| Muscular Dystrophy |  |  |
| Cleft Palate |  |  |
| Club Foot |  |  |
| Fetal Alcohol Syndrome |  |  |
| Born Drug Addicted |  |  |
| ADD/ADHD |  |  |
| Mental Retardation |  |  |
| Current Medication Prescribed/Required |  |  |
| **Alcohol and Drug** |  |  |
| Alcohol Use (Y/N) |  |  |
| Cigarette Use (Y/N) |  |  |
| Marijuana Use (Y/N) |  |  |
| Cocaine Use (Y/N) |  |  |
| Methamphetamines (Y/N) |  |  |
| Barbiturates (Y/N) |  |  |
| Other (list) |  |  |
| Treatment for substance abuse (type, date, facility ) |  |  |
| **Vision** |  |  |
| Current Optometrist/Eye Doctor |  |  |
| Eye Color |  |  |
| Current Vision Health |  |  |
| Glasses |  |  |
| Astigmatism |  |  |
| Far Sighted/Near Sighted |  |  |
| Cross Eyed/Other |  |  |
| Blindness/Serious Vision Problem |  |  |
| **Dental** |  |  |
| Current Dentist/Orthodontist |  |  |
| Current Dental Health |  |  |
| Dental Problems (Y/N-describe |  |  |
| Braces |  |  |
| **Hearing** |  |  |
| Current Audiologist |  |  |
| Hearing Problems (Y/N-describe) |  |  |
| Deafness/Serious Hearing Problems |  |  |
| **Speech** |  |  |
| Current Speech Pathologist |  |  |
| Speech Problems (Y/N-describe) |  |  |
| Mute/Serious Speech Problems |  |  |
| **Mental Health** |  |  |
| Current Psychologist/Psychiatrist/Counselor |  |  |
| Current Mental Health |  |  |
| Diagnosed Mental Illness |  |  |
| Medication Prescribed/Required |  |  |

**This section relates to the identified child’s siblings.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Background Information** | **Sibling** | **Sibling** | **Sibling** | **Sibling** |
| Name |  |  |  |  |
| Alias-Maiden Name |  |  |  |  |
| Step Sibling (Y/N) |  |  |  |  |
| Address |  |  |  |  |
| Phone Number |  |  |  |  |
| Date of Birth |  |  |  |  |
| Place of Birth |  |  |  |  |
| Race |  |  |  |  |
| Tribe |  |  |  |  |
| Enrollment Number |  |  |  |  |
| Marital Status |  |  |  |  |
| Religion |  |  |  |  |
| Deceased (Y/N) |  |  |  |  |
| Cause of Death |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Employment** | **Sibling** | **Sibling** | **Sibling** | **Sibling** |
| Current Employer |  |  |  |  |
| Type of Employment |  |  |  |  |
| Length of Time at this Job |  |  |  |  |
| Military Service |  |  |  |  |
| Date and Place of Military Services |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Education** | **Sibling** | **Sibling** | **Sibling** | **Sibling** |
| Last Grade Completed |  |  |  |  |
| Learning Disabilities |  |  |  |  |
| Name of School and Location |  |  |  |  |
| Diploma/GED |  |  |  |  |

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| --- | --- | --- | --- | --- |
| **Physical & Mental Health** | **Sibling** | **Sibling** | **Sibling** | **Sibling** |
| **Physical Health** |  |  |  |  |
| Weight |  |  |  |  |
| Height |  |  |  |  |
| Distinguishing Marks-Tattoos |  |  |  |  |
| Current Health Condition |  |  |  |  |
| Heart Disease |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Diabetes |  |  |  |  |
| Cancer |  |  |  |  |
| Seizures, Convulsions, Epilepsy |  |  |  |  |
| Cerebral Palsy |  |  |  |  |
| Paralysis or Crippling Disorder |  |  |  |  |
| Multiple Sclerosis |  |  |  |  |
| Muscular Dystrophy |  |  |  |  |
| Cleft Palate |  |  |  |  |
| Club Foot |  |  |  |  |
| Fetal Alcohol Syndrome |  |  |  |  |
| Born Drug Addicted |  |  |  |  |
| ADD/ADHD |  |  |  |  |
| Mental Retardation |  |  |  |  |
| Current Medication Prescribed/Required |  |  |  |  |
| **Alcohol and Drug** |  |  |  |  |
| Alcohol Use (Y/N) |  |  |  |  |
| Cigarette Use (Y/N) |  |  |  |  |
| Marijuana Use (Y/N) |  |  |  |  |
| Cocaine Use (Y/N) |  |  |  |  |
| Methamphetamines (Y/N) |  |  |  |  |
| Barbiturates (Y/N) |  |  |  |  |
| Other (list) |  |  |  |  |
| Treatment for substance abuse (type, date, facility) |  |  |  |  |
| **Vision** |  |  |  |  |
| Eye Color |  |  |  |  |
| Current Vision Health |  |  |  |  |
| Glasses |  |  |  |  |
| Astigmatism |  |  |  |  |
| Far Sighted/Near Sighted |  |  |  |  |
| Cross Eyed/Other |  |  |  |  |
| Blindness/Serious Vision Problem |  |  |  |  |
| **Dental** |  |  |  |  |
| Current Dental Health |  |  |  |  |
| Dental Problems (Y/N-describe |  |  |  |  |
| Braces |  |  |  |  |
| **Hearing** |  |  |  |  |
| Hearing Problems (Y/N-describe) |  |  |  |  |
| Deafness/Serious Hearing Problems |  |  |  |  |
| **Speech** |  |  |  |  |
| Current Speech Pathologist |  |  |  |  |
| Speech Problems (Y/N-describe) |  |  |  |  |
| Mute/Serious Speech Problems |  |  |  |  |
| **Mental Health** |  |  |  |  |
| Current Mental Health |  |  |  |  |
| Diagnosed Mental Illness |  |  |  |  |
| Medication Prescribed/Required |  |  |  |  |

**INFORMATION ON EXTENDED FAMILY MEMBERS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Background Information** | **Maternal Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** |
| Name |  |  |  |  |
| Alias-Maiden Name |  |  |  |  |
| Step Parent (Y/N) |  |  |  |  |
| Address |  |  |  |  |
| Phone Number |  |  |  |  |
| Date of Birth |  |  |  |  |
| Place of Birth |  |  |  |  |
| Race |  |  |  |  |
| Tribe |  |  |  |  |
| Enrollment Number |  |  |  |  |
| Marital Status |  |  |  |  |
| Religion |  |  |  |  |
| Deceased (Y/N) |  |  |  |  |
| Cause of Death |  |  |  |  |

**Indicate the name of any extended relative known to have listed condition.**

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| --- | --- | --- | --- | --- |
| **Physical & Mental Health** | **Name** | **Name** | **Name** | **Name** |
| **Physical Health** |  |  |  |  |
| Heart Disease |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Diabetes |  |  |  |  |
| Cancer |  |  |  |  |
| Seizures, Convulsions, Epilepsy |  |  |  |  |
| Cerebral Palsy |  |  |  |  |
| Paralysis or Crippling Disorder |  |  |  |  |
| Multiple Sclerosis |  |  |  |  |
| Muscular Dystrophy |  |  |  |  |
| Cleft Palate |  |  |  |  |
| Club Foot |  |  |  |  |
| Fetal Alcohol Syndrome |  |  |  |  |
| Born Drug Addicted |  |  |  |  |
| ADD/ADHD |  |  |  |  |
| Mental Retardation |  |  |  |  |
| **Alcohol and Drug** |  |  |  |  |
| Alcohol Use (Y/N) |  |  |  |  |
| Cigarette Use (Y/N) |  |  |  |  |
| Marijuana Use (Y/N) |  |  |  |  |
| Cocaine Use (Y/N) |  |  |  |  |
| Methamphetamines (Y/N) |  |  |  |  |
| Barbiturates (Y/N) |  |  |  |  |
| Other (list) |  |  |  |  |
| Treatment for substance abuse (type, date, facility) |  |  |  |  |
| **Vision** |  |  |  |  |
| Blindness/Serious Vision Problem |  |  |  |  |
| **Hearing** |  |  |  |  |
| Hearing Problems (Y/N-describe) |  |  |  |  |
| Deafness/Serious Hearing Problems |  |  |  |  |
| **Mental Health** |  |  |  |  |
| Diagnosed Mental Illness |  |  |  |  |