Breathe Mind Body Therapy
PARENT/CAREGIVER FORM

Today's Date: Client's Full Legal Name:

Date of Birth:

Your Name:

Relationship to Child:

Referral Source:

Please help me to understand your child's needs by sharing the following information. Please attempt to answer all the questions.

1) Current Concerns (What are the main reasons you are seeking help?)

Issue	**Primary Issue**	**Important**
Personal/Emotional Issues	☐	☐
Family Relationships	☐	☐
School Problems/Grades	☐	☐
Parent Marital Issues	☐	☐
Child/Parenting Concerns	☐	☐
Behavioral Problems	☐	☐
Health Problems	☐	☐
Other Life Stressors	☐	☐

Other:_____

_____

_____

_____

_____

How long have these problems been going on?_____

_____

_____

_____

What have you done to address these problems?_____

_____

_____

_____

What do you think is causing these problems?_____

_____

_____

_____

_____

_____

Have you/your family or client experienced any major life changes in the past few months?

_____

_____

_____

_____

_____

2) Do you have any immediate safety concerns, such as your child is at risk of harming him/herself, at risk of harming others, or at risk of being harmed? If so, please describe.

_____

_____

_____

_____

Any history of suicidality/homicidality for child? ☐ Yes ☐ No

Suicide attempt(s)? ☐ Yes ☐ No

How/when?_____

Current suicidal thoughts? ☐ Yes ☐ No

Plan?_____

Homicidal/violent thoughts/plans? ☐ Yes ☐ No

Describe:_____

3) Please mark the emotional concerns you have for your child:

- ☐ Agitated
- ☐ Anxious
- ☐ Apathetic
- ☐ Avoidant
- ☐ Confusion
- ☐ Developmental regression/Loss of Skill
- ☐ Fears or Phobias (excessive)
- ☐ Emotional/Social Developmental Lag
- ☐ Fidgety
- ☐ Hallucinations
- ☐ Hopeless
- ☐ Hypervigilant
- ☐ Irritable Moody/Labile
- ☐ Nervous Mannerisms
- ☐ Other Self Harm
- ☐ Paranoia
- ☐ Strange Beliefs/ideas
- ☐ Sad
- ☐ Separation Anxiety
- ☐ Suicide Attempts
- ☐ Suicidal Thoughts/Plans
- ☐ Thinks About Traumatic Events
- ☐ Tearful/Cries Easily
- ☐ Unaware of Environment
- ☐ Wants to be Left Alone
- ☐ Withdrawn
- ☐ Worried
- ☐ Over-reactive
- ☐ Other (specify)

Primary setting(s) of concern: ☐ Home ☐ School/Childcare ☐ Community

4) Please mark the behavioral concerns you have for your child:

- ☐ Aggressive Behavior
- ☐ Argues
- ☐ Breaks Laws/Rules
- ☐ Avoidant
- ☐ Destroys Property
- ☐ Destroys Things
- ☐ Difficulty with Directions
- ☐ Difficulty Transitioning
- ☐ Disobeys
- ☐ Excessive Tantrums
- ☐ Fidgets Frequently
- ☐ Gang Involvement
- ☐ Harmful to Animals
- ☐ Has set Fires
- ☐ Hyperactive
- ☐ Inattentive
- ☐ Impulsive
- ☐ Lies
- ☐ Non-compliant
- ☐ Oppositional/Defiant
- ☐ Perseverative
- ☐ Physical or Sexual Harm to Others
- ☐ Prostitution
- ☐ Repetitive Odd Behaviors
- ☐ Self-endangering/Lacks Sense of Caution
- ☐ Self-injurious
- ☐ Sexual Aggression
- ☐ Sexualized Behaviors
- ☐ Wanders Away/Runs Away
- ☐ Steals
- ☐ Vandalizes
- ☐ Other (specify)

Primary setting(s) of concern: ☐ Home ☐ School/Childcare ☐ Community

5) Please mark your child's physical complaints/concerns:

Sleep Concerns:

☐ Difficulty Falling Asleep ☐ Nightmares ☐ Night Terrors

☐ Resists Bedtime ☐ Sleeps All of the Time/Excessive Sleep

☐ Tired ☐ Wakes up During the Night

Dietary Concerns:

☐ Eats Excessively ☐ Eats Non-food Items ☐ Food Refusal

☐ Food related Sensory Concerns ☐ Hard to Please (Food) ☐ Hoards Food

☐ Poor Appetite ☐ Purges ☐ Binges

☐ Restricts Food Intake ☐ Vomits ☐ Weight Gain/Loss

☐ Other (specify)

Somatic and Sensory Concerns:

☐ Additional Physical Complaints (Specify) ☐ Headaches

☐ Stomach Aches ☐ Sensory Hypersensitivity (sight, sound touch)

☐ Sensory Hypersensitivity (sight, sound touch)

Toileting Issues:

☐ Never Toilet Trained

☐ Enuresis - Wets Bed/Clothing ☐ Day ☐ Night ☐ Both

☐ Encopresis - Soils Bed/Clothing ☐ Day ☐ Night ☐ Both

☐ Other Toileting Issues (Specify)

Primary setting(s) of concern: ☐ Home ☐ School/Childcare ☐ Community

Food or Environmental Allergies:

☐ No

☐ Yes (Specify):

Allergies to Medications:

☐ No

☐ Yes (Specify):

Health Concerns:

☐ Asthma ☐ Chronic Ear Infections ☐ Diabetes

☐ Hearing Problems ☐ Hypothyroidism/Hyperthyroidism

☐ Migraine Headaches ☐ Reflux ☐ Seizures

☐ Vision Problems

☐ Frequent Injuries: _____

_____

☐ Relevant Medical History (head injuries, surgeries, birth defects, physical illnesses): _____

_____

_____

6) Prenatal and Natal History

☐ Prenatal Medical Care ☐ Prenatal Accidents/Injuries

☐ In-utero Exposure to Drugs ☐ In-utero Exposure to Alcohol

☐ Low Birth Weight (<5 lbs) ☐ Premature (<37 wks)

☐ Failure to Thrive ☐ NICU Stay

☐ Other Birthing Complications ☐ Other Prenatal Concerns

7) Early Childhood Developmental History:

☐ Walked On-Time ☐ Talked On-Time

☐ Potty Trained On-Time ☐ Speech/Language Delays

☐ Other Developmental Concerns

8) Child's Mental Health History:

Outpatient Mental Health Services:	☐ not applicable	☐ current	☐ past
Inpatient Mental Health Services:	☐ not applicable	☐ current	☐ past
Treatment for Substance Use/Abuse:	☐ not applicable	☐ current	☐ past
School-based Mental Health Services:	☐ not applicable	☐ current	☐ past
Previous Family Therapy:	☐ not applicable	☐ current	☐ past
Psychiatric Services:	☐ not applicable	☐ current	☐ past
Taken psychiatric medication:	☐ No	☐ Yes	

(Drug name/dosage/dates)

_____

_____

_____

9) Child's Substance Use/Abuse History:

Alcohol Use: ☐ None ☐ Monthly ☐ Weekly ☐ Daily

How much: ☐ None ☐ 1-2 ☐ 3-5 ☐ More than 5

Drink of choice: ☐ Beer ☐ Wine ☐ Hard Liquor

Do you think your child's use is a problem? ☐ Yes ☐ No ☐ Unsure

Drug Use: Marijuana: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

Other non-prescription substances: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

If yes, list what substances_____

Prescription drugs used not as prescribed: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

If yes, what prescriptions_____

Cigarettes: ☐ None ☐ Monthly ☐ Weekly ☐ Daily

Caffeine/Energy Drinks: ☐ None ☐ Monthly ☐ Weekly ☐ Daily

10) Family Background

Child's Legal Guardian:_____

Relationship to Child: _____

Child's Biological Mother:_____

Child's Biological Father:_____

Child's parents' marital status?

☐ Married ☐ Dating

☐ Together unmarried ☐ Remarried

☐ Separated ☐ Deceased _____(which parent)

☐ Divorced ☐ Other(specify)_____

Who lives in child's household?

NAME	AGE	RELATIONSHIP TO CLIENT

Is this a ☐ Relative Foster Home ☐ Non-relative Foster Home

☐ Stable Home/Placement ☐ Unstable Home/Placement

How long has the child lived there? _____

11) Family's/Child's Positive Supports and Strengths

☐ Supportive Friends ☐ Supportive Relatives ☐ Play Sports

☐ Good Grades ☐ Hobbies (Specify) ☐ School Activities

☐ Spiritual Activities ☐ Organized Activities ☐ Positive Coping Skills

☐ Other Natural Supports(Specify):

_____

_____

_____

12) What is the child's cultural background?

☐ Hispanic ☐ Asian/Pacific Islander ☐ African American

☐ Native American ☐ Anglo-American ☐ Other (Specify): _____

13) Family Mental Health and Substance Abuse History:

Has a family member had mental health problems? ☐ No ☐ Yes (Please explain):

_____

_____

_____

Has a family member had substance use/abuse problems? ☐ No ☐ Yes (Please explain):

_____

_____

_____

14) Psycho-Social History and Risk Factors:

Has your child experienced any of the following abuse, trauma, or difficult life circumstances?

Exposure to domestic violence:	☐ not applicable	☐ current	☐ past
Exposure to community violence:	☐ not applicable	☐ current	☐ past
Victim of community violence:	☐ not applicable	☐ current	☐ past

Witness to the abuse of others:	☐ not applicable	☐ current	☐ past
Unsafe neighborhood:	☐ not applicable	☐ current	☐ past
Victim of a crime:	☐ not applicable	☐ current	☐ past
Victim of disaster/terrorism:	☐ not applicable	☐ current	☐ past
Homeless:	☐ not applicable	☐ current	☐ past
Multiple Family Moves:	☐ not applicable	☐ current	☐ past
Relocated from another country:	☐ not applicable	☐ current	☐ past
Living in poverty:	☐ not applicable	☐ current	☐ past
Serious illness in client:	☐ not applicable	☐ current	☐ past
Serious illness in family:	☐ not applicable	☐ current	☐ past
Death of a loved one:	☐ not applicable	☐ current	☐ past
Caregivers' developmental disabilities:	☐ not applicable	☐ current	☐ past
Family legal difficulties/custody issues:	☐ not applicable	☐ current	☐ past
Client legal difficulties:	☐ not applicable	☐ current	☐ past
Alleged victim of physical abuse:	☐ not applicable	☐ current	☐ past
Alleged victim of sexual abuse:	☐ not applicable	☐ current	☐ past
Alleged victim of neglect:	☐ not applicable	☐ current	☐ past
Relationships with severe conflict:	☐ not applicable	☐ current	☐ past
Family lack of resources:	☐ not applicable	☐ current	☐ past
Family social isolation:	☐ not applicable	☐ current	☐ past
Disruption to attachment relationship:	☐ not applicable	☐ current	☐ past
History of Child Welfare involvement:	☐ not applicable	☐ current	☐ past
History of out-of-home placement:	☐ not applicable	☐ current	☐ past
History of foster placements:	☐ not applicable	☐ current	☐ past

If known, number of foster placements: _____

15) School Information:

Name of School: _____

Teacher: _____ Grade: _____

Number of Years at Current School:_____

History of Retention:	☐ No	☐ Yes	If yes, which grade(s):
History of Expulsion:	☐ No	☐ Yes	If yes, describe):

History of Suspension: ☐ No ☐ Yes If yes, describe):

History of Disciplinary Referrals: ☐ No ☐ Yes If yes, describe):

Attendance Patterns:

Student has missed: ☐ fewer than 5 days in the three months
☐ between 5 days and 15 days or more in the last three months

Absences were: ☐ mostly excused ☐ mostly unexcused.

Child's Academic Performance:

☐ Good (A's/B's) ☐ Average (C's) ☐ Poor (D's/F's) ☐ NA

Child's Classroom Behavior ☐ Good ☐ Fair ☐ Poor

Child's Social Skills/Network ☐ Good ☐ Fair ☐ Poor

Does your child have an IEP or a 504 plan? ☐ Yes ☐ No

Has your child been diagnosed with learning difficulties/disabilities? ☐ Yes ☐ No

Does your child receive school-based interventions? ☐ Physical Therapy ☐ Speech

☐ Reading Intervention ☐ Math Intervention ☐ Other (Specify)

16) How are your child's peer relationships?

☐ Appropriate relationships with peers ☐ Poor social skills ☐ Few/no friends

☐ Relationships with a lot of conflict ☐ Socially Withdrawn ☐ Is being bullied

☐ Is identified as a bully

_____

_____

_____

17) What are your child's strengths?

_____

_____

_____

18) What are your child's areas of opportunity?

_____

_____

_____

19) What are your parenting strengths?

_____

_____

_____

20) What are your parenting areas of opportunity?

_____

_____

_____

21) In your relationship with your child what is working well?

_____

_____

_____

22) In your relationship with your child what is not working well?

_____

_____

_____

_____

_____

23) What do you want to accomplish in treatment/What are your therapy goals?

_____

_____

_____

_____

_____

_____