WRIGHT STATE UNIVERSITY

The Ellis Institute
School of Professional Psychology
9 N. Edwin C. Moses Blvd
Dayton, OH 45402
Phone: 937-775-4300
Fax: 937-775-4311

Thank you for your referral for the Ellis Human Development Institute.

To make a Montgomery County Department of Jobs and Family Services- Children Services Division referral, please complete the attached MCDJFS Intake Packet and send to:

Ellis Human Development Institute
9 N. Edwin C. Moses Blvd.
Dayton, OH 45402

Or Fax to 937-775-4311

Referrals to the Ellis Institute must contain the following information in order to meet regulatory requirements and initiate a diagnostic assessment. If you have any questions about the enclosed information, please call 937-775-4300 and our clinical staff will be happy to assist with the referral process.

After we have the completed information, we will contact the foster parent, prospective adoptive parent, or the caseworker to schedule an intake appointment. Please identify who we should contact:
❑ Foster Parent ❑ Prospective Adoptive Parent ❑ MCDJFS Caseworker Other:_____

Intake Packet Checklist—Please complete all of the following forms in their entirety and send them to the address listed above:

❑ A copy of the current Custody Order or a statement on agency letterhead stating that your agency currently has custody of the child. The Custody Order must be received before the appointment can be scheduled.

❑ A release of information for the foster parent(s) and/or prospective adoptive parent unless it is requested that they not be a part of the assessment or treatment process.

❑ Any additional releases for other persons, agencies, or schools should be included.
Note: A release of information is not necessary between Ellis Human Development Institute and your organization if you have custody of the child. Release forms can be copied.

❑ MCDJFS-CSD Intake Referral Information Form

❑ Parent Background Form: please complete all 9 pages

❑ Health History Questionnaire: please complete all 4 pages through the top of page 4 (signature of person completing this questionnaire)

❑ Previous evaluations which are currently available (e.g., school ETR/IEP, Diagnostic Assessment from counselor or psychiatrist, evaluations conducted by MCDJFS, Child Study Inventory)

❑ Childhood Trust Survey: to be completed by an adult who is aware of the child's trauma history

❑ A signed copy of the Consent for Treatment and Client Orientation Checklist, giving permission to Ellis to provide services. Please initial and sign as indicated on the form.

❑ Disclosure Statement: Please enter the child's name at the top and sign the form at the bottom. Once the case is assigned to a clinician, we will fax you a copy of the form with the clinician's name and supervisor's name for your records.

Note: A copy of the Ellis Humans Development Institute's Note of Privacy Practices is also included with this packet for your review. There is also a link to our Notice of Privacy Practices on our website.

WRIGHT STATE UNIVERSITY

ELLIS HUMAN DEVELOPMENT INSTITUTE

MCDJFS Intake Referral Information

Referral Date:_____ Person Completing form: _____ Phone: _____

Caseworker Name: _____ Caseworker Phone: _____

May we leave a message? ❑ Yes ❑ N

Child's Name: (Last, First, MI): _____

DOB:_____ Gender: _____ Preferred spoken language: _____

Social Security #: _____CareSource #: _____

Caretaker Name: _____ Caretaker Phone: _____

Caretaker Address:_____

Current Medications: _____

_____

Lethality/Safety Issues: _____

_____

School/Grade/Special Education Placement:_____

_____

Counseling History**:**_____

Previous Assessments**:** _____

Relevant Social History Including Placement History, Number of Disruptions, and Family History:

_____

_____

_____

_____

_____

Recommendations/Request/Reasons for Referral: _____

_____

_____

Client Orientation to Services Checklist & Consent to Treat—MCDJFS-CSD

I acknowledge that I have received and understand the Ellis Human Development Institute (EHDI) orientation information that consists of:

Client Initials	Orientation Requirement	
Get Client Signature Here →	**Consent to Treat** I agree and hereby give consent for the Ellis Institute to provide services to me and/or my child under the conditions identified in the paragraphs below. In addition, I acknowledge that any psychological tests used will not be released to me, that test data and personal data may be collected and processed through the publisher's electronic scoring system, and that the publisher of psychological testing materials may gain access to the test data scored and my electronic protected health information. **Client/Guardian Signature*:*** _____	Support Staff Initials
Get Client Signature Here →	**Video Taping** I understand that most services provided as part of the contract between the Ellis Human Development Institute and the Montgomery County Department of Job and Family Services will not be audio or video recorded. However, if the evaluation includes the Marschak Interaction Method (MIM), a structured observation of the parent-child relationship, the MIM will be video-recorded for supervision and scoring purposes. The MIM video recording is not part of the client's record and, as such, will not be released to the client/guardian**. Please sign below:** * I consent to video/audio recording for the MIM:_____ * I decline video/audio recording for the MIM: _____	**Support Staff Initials**
Initial Here	**Training Clinic** I understand that Ellis Institute is a training, service and research center and services are provided by doctoral level students who are under the supervision of licensed psychologists. • If you are asked to participate in a research project, you will also be asked to sign a separate consent. Participation in research is always voluntary. Not participating in a research project does not affect your services.	Support Staff Initials
Initial Here	**Receipt of HIPAA Privacy Policy** I acknowledge that I have received the Ellis Institute's HIPAA Privacy Policy, which was attached to this packet, entitled: *Notice of Privacy Practices* or available for download from the website.	
Initial Here	**Client Services Handbook** I acknowledge that I have access to a copy of the Ellis Institute's Client Service Pamphlet, which includes the following information: • Client Rights & Responsibilities, Information on Advanced Directives • Grievance Procedures • Therapy and Treatment Planning Processes (Includes transition/discharge planning, Satisfaction Surveys, quality of care & outcome achievement) • Assessment of Needs • Risks & Benefits of Treatment • Client Code of Ethics • Attendance & Cancellation Guidelines. • Program Rules (Includes Involuntary Termination) • No use of Seclusion and Restraint, no smoking, illicit or licit drugs or weapons brought into the facility. • Confidentiality and Exceptions to Confidentiality • Motivational incentives when appropriate (bus tokens, food, gift cards.)	
Fire Exit Locations and Evacuations		Support Staff Initials
Legal Rule with Minors		Provider Initial Below
➢ Disclosed to minor that parent and/or guardian has a right to access minor's records.		

I was given the opportunity to ask questions. I understand I can have these booklets read to me if I am unable to read them.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
EHDI Provider Signature Date

Rev: 6/6/2016, 6/19/2017, 8/8/2018, 10/5/18

WRIGHT STATE UNIVERSITY

School of Professional Psychology

Duke E. Ellis
Human Development Institute
9 North Edwin C. Moses Blvd.
Dayton, Ohio 45402-8470
(937) 775-4300
fax: (937) 775-4323
psychology.wright.edu

DISCLOSURE STATEMENT

Client Name:_____ Client ID#_____

The staff of Duke E. Ellis Human Development Institute includes licensed psychologists, psychology fellows, psychology interns, and psychology trainees with a range of training and experience. Services provided by the Psychology staff include individual, family, couples, and group psychotherapy, psychological testing and assessment, psychoeducation, and consultation services. If your mental health provider is a psychology trainee, a psychology intern, or a psychology fellow, he or she will be supervised by a licensed psychologist. The supervisor has ultimate professional responsibility for your care and, as such, all supervisees are required to discuss your treatment, including the content of your sessions, your progress, and psychological testing results, with the supervisor. You have the right to know the status of the provider working with you, to know the identity of his or her supervisor, and to meet with that supervisor if you so desire.

Supervisee assigned to your case is:_____ Phone: (937) 775-4300

His/her supervisor is: _____ Phone: (937) 775-4300

Supervisor's Ohio License Number is:_____

As you enter treatment, a client record or file is opened which includes information about your history, service plan, medications, progress, and any testing results or correspondence which may be generated. This information is shared only with those involved in your treatment or with other staff within Duke E. Ellis Human Development Institute who may be consulted about your case. You must provide written consent before this information is shared with anyone outside of Duke E. Ellis Human Development Institute; however, Duke E. Ellis Human Development Institute may release information without your consent if the law requires that we do so. This might occur if (a) a court order is received; (b) there is an emergency or a situation which threatens your life or the life of another; or (c) it is suspected that child or elder abuse and/or neglect has occurred, or there is abuse of a developmentally disabled "vulnerable" adult. Knowledge/belief of domestic violence/abuse will be noted in the client records. (Other information regarding disclosure of information is outlined in the Client Services Handbook.)

The frequency of appointments will be determined by the mental health provider with input from the client. Appointments will be scheduled by the mental health provider or office staff, unless other arrangements are made. If illness or an emergency prevents you from keeping a scheduled appointment, please contact Duke E. Ellis Human Development Institute as soon as possible. Cost of services and billing will be consistent with Duke E. Ellis Human Development Institute's policies.

Supervisors do not typically provide back-up coverage for supervisees (i.e., psychology fellows, psychology interns, and psychology trainees). In the event that a supervisee is temporarily or permanently unable to speak to or meet with clients on their caseload, backup coverage will be arranged in accordance with the policy in place at Duke E. Ellis Human Development Institute.

Mental health services are generally provided at:

Duke E. Ellis Human Development Institute
Wright State University
9 N. Edwin C. Moses Boulevard
Dayton, OH 45402

At times, services may be delivered in another location.

For emergency services at a time when Duke E. Ellis Human Development Institute is closed, you may contact Crisis Care (937-224-4646) or go to the nearest emergency room.

I understand and agree to the above conditions. I understand that my signature indicates my consent to treatment by a supervisee at Duke E. Ellis Human Development Institute.

_____ _____
Client or Parent/Guardian Date

_____ _____
Supervisee Date

_____ _____
Supervisor Date

HEALTH HISTORY QUESTIONNAIRE

This form should be completed as fully as possible by client but reviewed by medical or clinical staff. Clients should notify staff if they need any assistance in completing this form.

Client Name (First, MI, Last)	**Client No.**	**Age**

Has the client had any of the following health problems?

	Now	**Past**	**Never**	**Treatment Received and Date(s)**
Anemia				
Arthritis				
Asthma				
Bleeding Disorder				
Blood Pressure (high or low)				
Bone/Joint Problems				
Cancer				
Cirrhosis/Liver Disease				
Diabetes				
Epilepsy/Seizures				
Eye Disease/Blindness				
Fibromyalgia/Muscle Pain				
Glaucoma				
Headaches				
Head Injury/Brain Tumor				
Hearing Problems/Deafness				
Heart Disease				
Hepatitis/Jaundice				
Kidney Disease				
Lung Disease				
Menstrual Pain				
Oral Health/Dental				
Stomach/Bowel Problems				
Stroke				
Thyroid				
Tuberculosis				
AIDS/HIV				
Sexual Transmitted Disease				
Learning Problems				
Speech Problems				
Anxiety				
Bipolar Disorder				
Depression				
Eating Disorder				
Hyperactivity/ADD				
Schizophrenia				
Sexual Problems				
Sleep Disorder				
Other:				
Other:				
Other:				

Please note family history of any of the above conditions and client's relationship to that family member.

Client Name (First, MI, Last)	**Client No.**

Has client had medical hospitalizations/surgical procedures in the last 3 years?

☐Yes ☐No If yes, complete information below.

Hospital	City	Date	Reason

Allergies/Drug Sensitivities

☐None

☐Food (specify):

☐Medicine (specify):

☐Other (specify):

☐Not Applicable

Pregnancy History (if applicable)

Currently pregnant? If yes, expected delivery date. ☐No ☐Yes	**Receiving pre-natal healthcare?** If yes, indicate provider. ☐No ☐Yes
Last Menstrual Period Date	**Any significant pregnancy history?** If yes, explain. ☐No ☐Yes

Last Physical Examination

By Whom	**Date**	**Phone No. (if known)**

Has client had any of the following symptoms in the past 60 days? Please check.

☐Ankle Swelling	☐Coughing	☐Lightheadedness	☐Penile Discharge	☐Urination Difficulty
☐Bed-wetting	☐Cramps	☐Memory Problems	☐Pulse Irregularity	☐Vaginal Discharge
☐Blood in Stool	☐Diarrhea	☐Mole/Wart Changes	☐Seizures	☐Vision Changes
☐Breathing Difficulty	☐Dizziness	☐Muscle Weakness	☐Shakiness	☐Vomiting
☐Chest Pain	☐Falling	☐Nervousness	☐Sleep Problems	☐Other: _____
☐Confusion	☐Gait Unsteadiness	☐Nosebleeds	☐Sweats (night)	_____
☐Consciousness Loss	☐Hair Change	☐Numbness	☐Tingling in Arms & Legs	
☐Constipation	☐Hearing Loss	☐Panic Attacks	☐Tremor	☐Other: _____
				_____

☐Not Applicable

Immunizations

Immunizations (Child or DD only) - Has client had or been immunized for the following diseases? Please check.

☐Chicken Pox	☐Diphtheria	☐German Measles	☐Hepatitis B	☐Measles
☐Mumps	☐Polio	☐Small Pox	☐Tetanus	☐Other:

Immunizations Within the Past Year

Height/Weight

Height	**If reporting for a child, has height changed in the past year?** ☐No ☐Yes If yes, by how much (+ or -)?
Weight	**Has client's weight changed in the past year?** ☐No ☐Yes If yes, by how much (+ or -)?

Client Name (First, MI, Last)	**Client No.**

Nutritional Screening (please check)

☐ No Problem	**Eating** ☐ More ☐ Less ☐ Not Eating	**Drinking** ☐ More ☐ Less ☐ Takes Liquids Only	**Appetite** ☐ Increased ☐ Decreased

☐ Nausea ☐ Vomiting ☐ Trouble Chewing or Swallowing

Special Diet	**Other**

Pain Screening

Does pain currently interfere with your activities? If yes, how much does it interfere with these activities (please check)

☐ No ☐ Yes ☐ Not at All ☐ Mildly ☐ Moderately ☐ Severely ☐ Extremely

Please indicate the source of the pain.

Substance Use History/Current Use (please check appropriate columns)

Substance	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use	**Substance**	No Use	Past Use	Current Use
Alcohol/Beer/Wine				Sleep Medication				Cocaine/Crack			
Marijuana				Tranquilizers				Heroin			
Hashish				Hallucinogens				Pain Medication			
Stimulants				Inhalants				Other:			

Caffeine use? If yes, form (coffee, tea, pop, etc.) ☐ No ☐ Yes	**How much per week** (cups, bottles)**?**
Tobacco use? If yes, form (cigarettes, cigars, smokeless, etc.) ☐ No ☐ Yes	**How much per week** (packs, etc.)**?**

Was there any prenatal exposure to alcohol, tobacco, or other drugs? ☐ **Yes** ☐ **No** ☐ **I don't know**
If yes, please describe:

Are you currently prescribed medications?

☐ Yes ☐ No If yes, complete information below.

Medication	Dosage	Prescribing Physician

Please describe your use of complementary health approaches *(i.e. massage, chiropractic, homeopathic remedies, acupuncture, herbs, probiotics, etc.)*:

Client Name (First, MI, Last)	**Client No.**

Safety Screening

Our goal at the Ellis Institute is that all clients are safe. Please respond to the following questions. Your clinician will discuss these questions with you during your intake.

FOR ADULT CLIENTS:

1. **In the past two weeks, have you thought about harming yourself?** ☐ **Yes** ☐ **No**
2. **In the past two weeks, have you thought about killing yourself?** ☐ **Yes** ☐ **No**
3. **Have you ever made a suicide attempt?** ☐ **Yes** ☐ **No**

   If Yes, when? Please state the month & year _____

FOR CHILD/ADOLESCENT CLIENTS. PARENT/GUARDIAN, PLEASE COMPLETE THESE ITEMS:

1. **In the past two weeks, has your child thought about harming himself/herself/themselves?** ☐ **Yes** ☐ **No** ☐ **I don't know**
2. **In the past two weeks, has your child thought about killing himself/herself/themselves?** ☐ **Yes** ☐ **No** ☐ **I don't know**
3. **Has your child ever made a suicide attempt?** ☐ **Yes** ☐ **No** ☐ **I don't know**

   If Yes, when? Please state the month & year _____

Safety Screening

Our goal at the Ellis Institute is that everyone is safe. Please respond to the following questions. Your clinician will discuss these questions with you during your intake.

FOR ADULT CLIENTS:

1. **In the past two weeks, have you thought about harming other people** ☐ **Yes** ☐ **No**

FOR CHILD/ADOLESCENT CLIENTS. PARENT/GUARDIAN, PLEASE COMPLETE THIS Item:

1. **In the past two weeks, has your child thought about harming others?** ☐ **Yes** ☐ **No** ☐ **I don't know**

Print Name of Person Completing this Questionnaire	**Signature of Person Completing this Questionnaire**	**Date**

Clinician Reviewer Comments, if any

☐ Medical Review Recommended

Provider Signature/Credentials	**Date**

Referrals Needed ☐ No Referral Needed

Check Referral(s) Needed and Specify Action(s)

☐ Primary Care Physician: _____

☐ Healthcare Agency: _____

☐ Specialty Care: _____

☐ Other (specify): _____

Recommendations shared with client? ☐ **Yes** ☐ **No**

If no, how will recommendations be shared with client?

Provider Signature/Credentials	**Date**
Supervisor Signature/Credentials	**Date**

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The Ellis Human Development Institute
School of Professional Psychology
9 N. Edwin C. Moses Blvd
Dayton, OH 45402
Phone: 937-775-4300
Fax: 937-775-4311

Authorization for Release of Protected Health Information

Client Name: _____ Client #: _____ Birth Date: _____

Social Security #: _____ Name of Provider: _____

I hereby grant my permission for release, review, and exchange of the following information relating to my care between the parties named here. This release is intended to cover all services provided by the Ellis Human Development Institute.

I am aware that once this information is released to another party, it may no longer be protected. I understand that I may further limit the type of exchange between the listed parties. List limitations, if any: _____

Ellis Human Development Institute	AND	
9 N. Edwin C. Moses Blvd.		
Dayton, OH 45402		
Phone: (937) 775-4300 FAX: (937) 775-4311		

Purpose of this request: [check all that may apply during the timeframe of this release]
❑ Continuity of Care/Treatment ❑ Legal ❑ Insurance Claim ❑ Patient Request ❑Other, specify:_____
_____

Ways information may be shared: [check all that may apply during timeframe of this release]
❑ Mail ❑ Fax ❑Phone ❑ In Person ❑Picked Up
_____

The following information pertaining to the patient named above:
Dates of Treatment: _____

I specify that this release/exchange is to include (choose all that apply):

	Drug/Alcohol Abuse Assessment		Medications Prescribed		Final Discharge
	Mental Health Assessment		Pathology / Laboratory Reports		Discharge Summary
	Psychological Assessment		Operative Reports		Physical Exam
	Drug/Alcohol Treatment		Emergency Room Treatment		Consultation
	Mental Health Treatment		Physical Orders		
	Other Specified → → →				

- I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection, treatment for drug or alcohol abuse, or mental or behavioral health or psychiatric care.
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.
- I understand that I have the right to revoke this authorization at any time. My revocation must be in writing in a letter to Ellis Human Development Institute at the address listed on this authorization form. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.
- Unless otherwise revoked, I understand that this authorization will expire one hundred and eighty (180) days from the date of this form or on the following date or event: _____.
- I understand that I may refuse to sign this authorization and that Ellis Human Development Institute may not condition treatment on the completion of this authorization except as indicated in HIPPA Regulations at 45 CFR §164-508(b)(4).
- I certify that I have read and received a copy of the authorization. This authorization supersedes any and all previous authorizations.

A copy or facsimile of this document will be considered as an original

_____ _____ _____ _____
Signature Date Witness Date

I hereby consent to the above for a minor or person unable to assume personal responsibility.

_____ _____ _____
Signature Date Relationship to Client

FOR OFFICE USE ONLY	
Date signed by client/guardian	
Authorization Expiration Date (180 days)	
If REVOKED, Date of Revocation	

This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

Rev. 8/24/17

Caregiver Form

ID _____

Date _____

DOB/age _____

The Childhood Trust Events Survey

Children and Adolescents: Caregiver Form

Version 2.0; 10/10/2006

It is important for us to understand what may have happened to your child. The questions below describe some kinds of upsetting experiences. Since we give these questions to everyone, we list a lot of possible events that may have happened at any time in your child's life. If one or more of these experiences has happened at some time in your child's life, please circle **Y** for **Yes**. If not, circle **N** for **No**. If you are unsure, circle **DK** for **Don't Know**. Thank you for completing this survey.

1.	Was your child ever in a really bad accident, such as a serious car accident?	Y	N	DK
2.	Was your child ever in a disaster such as a tornado, hurricane, fire, big earthquake, or flood?	Y	N	DK
3.	Was your child ever so badly hurt or sick that he/she had to have painful or frightening medical treatment?	Y	N	DK
4.	Has your child ever been threatened or harassed by a bully (someone outside of his/her family)?	Y	N	DK
5.	Has your child ever repeatedly had a parent swear at him/her, insult him/her, or had hurtful things said to him/her such as "You are no good," "You will be sent away because you are bad," or "I wish you were never born"?	Y	N	DK
6.	Was your child ever completely separated from his/her parent(s) for a long time, such as going to a foster home, the parent living far apart from him/her, or never seeing the parent again?	Y	N	DK
7.	Has your child ever had a family member who was put in jail or prison or taken away by the police?	Y	N	DK
8.	Has your child ever had a time in his/her life when he/she did not have the right care, such as not having enough to eat, being left in charge of younger brothers or sisters for long periods of time, or being left with an adult who used drugs?	Y	N	DK
9.	Has your child ever had a time in his/her life when he/she was living in a car, living in a homeless shelter, living in a battered women's shelter, or living on the street?	Y	N	DK
10.	Has your child ever had someone living in his/her home who abused alcohol or used street drugs?	Y	N	DK
11.	Has your child ever seen someone in the home try to hurt or kill himself/herself, such as cutting himself/herself or taking too many pills or drugs?	Y	N	DK

Page 1 subtotals ___ ___ ___

12. Has your child ever had a family member who was depressed or mentally ill for a long time?	Y	N	DK
13. Has your child ever had a family member or someone else very close to him/her die unexpectedly?	Y	N	DK
14. Has someone in your child's home ever been physically violent toward him/her, such as whipping, kicking, or hitting hard enough to leave marks?	Y	N	DK
15. Has an adult ever said they were going to hurt your child really badly or kill him/her, or acted like they were going to hurt your child very badly or kill him/her, even if this person didn't actually do it?	Y	N	DK
16. Has your child ever seen or heard family members act like they were going to kill or hurt each other badly, even if they didn't actually do it?	Y	N	DK
17. Has your child ever seen or heard a family member being hit, punched, kicked very hard, or killed?	Y	N	DK
18. Has your child ever seen someone in his/her neighborhood be beaten up, shot at or killed?	Y	N	DK
19. Has someone ever robbed or tried to rob (jump) your child or your child's family with a weapon?	Y	N	DK
20. Has someone ever kidnapped your child or has someone close to your child ever been kidnapped?	Y	N	DK
21. Has your child ever been badly hurt by an animal, such as attacked by a dog?	Y	N	DK
22. Has your child ever had a pet or animal that was hurt or killed on purpose by someone he/she knew?	Y	N	DK
23. Has your child ever seen a friend killed?	Y	N	DK
24. Has someone ever touched your child's private sexual body parts when he/she did not want them to?	Y	N	DK
25. Has someone ever made your child touch another person's private sexual body parts?	Y	N	DK
26. Has an adult ever tied your child up, gagged him/her, blindfolded him/her, or locked him/her in a closet or a dark scary place?	Y	N	DK
Page 2 subtotals	___	___	___
Page 1 subtotals	___	___	___
Total	___	___	___

If more than one event happened AND still seems to bother your child, put a star next to the one that you believe bothers him/her the most.

Trauma Treatment Training Center
The Childhood Trust & The Mayerson Center for Safe and Healthy Children
Cincinnati Children's Hospital Medical Center
3333 Burnet Ave, MLC 3008 Cincinnati, Ohio 45229-3039

WRIGHT STATE UNIVERSITY

ELLIS HUMAN DEVELOPMENT INSTITUTE

PARENT BACKGROUND FORM

Please answer all of the following questions as honestly as possible with a BLUE or BLACK INK PEN.

CLIENT NAME: _____ **NUMBER:** _____ **DATE:** _____

DATE OF BIRTH: _____ **SEX: M __ F ___**

FORM COMPLETED BY: _____

RELATIONSHIP TO CHILD: _____
(Please indicate if child is adopted)

Why are you referring your child for services at this time: _____

Who referred you to us: _____

MEDICAL HISTORY

1. **The child's present state of health is: ___Good ___Fair ___ Poor**

2. **Does she/he currently have any medical problem(s)? ___No ___Yes**
   If you answered "yes," please indicate the nature of the problem(s): _____
   _____
   _____

3. **When was she/he last treated by a physician? Date:** _____
   Please indicate where: ___Private ___Physician ___Clinic
   Name of Physician or Clinic: _____
   Address: _____
   _____

4. **When did she/he receive his/her last physical? Date:** _____
   Name of Physician or Clinic: _____
   Address: _____
   _____

5. **Do you have a family physician: ___No ___Yes**
   Name of Physician: _____
   Address: _____
   _____

6. **Please check any of the following which have been a problem for your child:**
   ___ Sleep problems **___ Problems w/ motor coordination**

____	High or prolonged fever	____	Shortness of breath
____	Convulsions	____	Low blood pressure
____	Unconsciousness	____	Ulcers
____	Allergies	____	Underweight
____	Asthma	____	Overweight
____	High blood pressure	____	Epilepsy
____	Vision Problems	____	Menstrual problems
____	Stomach trouble	____	Hernia
____	Dizziness	____	Chronic Cough
____	Constipation	____	Bladder infections
____	Vaginal infections	____	Problems w/ motor coordination
____	Low blood pressure	____	Shortness of breath
____	Other, please specify: _____		

7. **Does this child have any allergies? ___No ___Yes**
If "yes," please name the drug(s), food(s), or other substance(s) to which she/he is allergic: _____

EARLY DEVELOPMENT

1. **Did the mother have any difficulties with the pregnancy, labor, or delivery of this child? ___No ___Don't Know ___Yes**
If 'Yes', please specify: _____

2. **What was the child's weight at birth: ____lbs. ____oz.**

3. **Did the child have any problems at birth? __No ___Don't Know ___Yes**
If 'Yes', please specify: _____

4. **Was this child's rate of development normal during the first 18 months?**
___No ___Don't Know ___Yes
If 'Yes', please specify: _____

5. **Please check the appropriate age at which your child performed the following:**

	Under 6 Months	Between 6 Mths-1 Year	Between 1 & 1½ Years	Over 1½ Years	Unknown
Crawled	___	___	___	___	___
Walked	___	___	___	___	___

Talked	___	___	___	___	___
Toilet Trained	___	___	___	___	___

5. Check any of the following which describe how you felt about having this child:

___Happy ___Unprepared ___Unhappy
___Nervous ___Life disrupted ___Financially burdened
___Excited ___Fulfilled
___Other, please specify: _____
_____
_____

6. Which of the following best describes this child as an infant?

___Fun ___Sickly ___Fussy
___Overactive ___Quiet ___Irritating

Summary
(please do not write in this space)

_____
_____
_____
_____

SOCIAL AND FAMILY HISTORY

1. What grade is this child in now? _____
2. How many different schools has this child attended? _____
3. What kind of grades does she/he make in school? _____
   ___Excellent ___Good ___Fair ___Poor ___Failing
4. Has this child ever repeated a grade? ___No ___ Yes
   If 'Yes', please specify: _____
   _____
   _____
5. Has this child ever had specialized testing at school?
   ___No ___Yes
   If 'Yes', please specify: _____
   _____
   _____
6. How would you describe the child's school attendance? ___Good ___Fair ___Poor
7. Does this child have problems in school? ___No ___Yes
   If 'Yes', please specify: _____

_____

_____

8. How well does this child get along with other children?

___Very well ___Not very well

___Satisfactory ___Very poorly

9. Does this child participate in school activities? ___No ___Yes, some ___Yes, many

10. Choose those characteristics which describe your child's attitude toward authority figures (teachers, parents, etc.)

___	Assertive	___	Cooperative
___	Defiant	___	Excessive demands for attention
___	Fearful	___	Overly anxious to please
___	Respectful	___	Shy
___	Submissive	___	Uncooperative

11. Are most of this child's close friends: ___Same age ___Older ___Younger

12. Are most the child's close friends: ___Same age ___Opposite sex ___Both sexes

13. What does this child do well? _____

_____

_____

14. Does this child have interests or hobbies she/he enjoys? ___No ___Yes

If 'Yes', please specify: _____

_____

_____

15. Does this child have a strong fear about any of the following?

___	Being left alone	___	Being in crowds
___	The dark	___	Strangers
___	Any animals or insects	___	Bodily harm
___	Thunder or lightning	___	Death
___	Closed in places	___	Riding in a car
___	High places	___	No known fears
___	Other, please specify: _____		

_____

16. Check any of the following which apply to your child:

___	Lonely	___	Obedient	___	Clumsy
___	Dependable	___	Destructive of property	___	Energetic
___	Fire setting	___	Sleep-walking	___	Shy
___	Friendly	___	Acts young	___	Artistic for age
___	Cruel to animals	___	Acts old for age	___	Overactive

___	Rigid/compulsive	___	Feelings easily hurt	___	Impulsive
___	Intelligent	___	Easily influenced	___	Clinging
___	Daydreaming	___	Sleep problem	___	Stubborn
___	Messy	___	Sense of humor	___	Lazy
___	Bed wetting	___	Nail-biting	___	Tells lies
___	Irresponsible	___	Self-confident	___	Considerate
___	Cries easily	___	Fights constantly	___	Steals
___	Loving	___	Likes to be alone	___	Jealous
___	Often sad	___	Unsure of self	___	Nightmares
___	Nervous	___	Temper tantrums	___	Short attention span
___	Independent	___	Many physical complaints		

17. Has your child ever had previous treatment for any of the above? ___No ___Yes
Whom did she/he see? _____

Address: _____
_____

18. Did anything happen that affected the family shortly before your child's behavior problem occurred?

___Death – Specify: _____
_____
___Job change – Specify: _____
_____
___Divorce/Separation – Specify: _____
_____
___ Birth/Adoption – Specify: _____
_____
___Other – Specify: _____
_____
___No

21. Check all persons with whom this child has lived most of her/his life and indicate how well s/he gets along with these people.

	GOOD	FAIR	POOR
Natural Mother	___	___	___
Natural Father	___	___	___
Stepmother	___	___	___
Stepfather	___	___	___
Adoptive parents	___	___	___

Foster parents	___	___	___
Brothers (list)	___	___	___
	___	___	___
Sisters (list)	___	___	___
	___	___	___
Other relative(s) (who?)	___	___	___
	___	___	___
Institution (where?)	___	___	___

22. **Whom does child live with now?** _____

23. **In your family, who likes your child best?** _____

24. **In your family, who likes her/him least?** _____

25. **Does your child remind you of anyone else (yourself, spouse, a relative)?**
___No ___Yes
If 'Yes', please specify: _____
_____
_____

26. **Does another child in this family have a serious medical or emotional problem?**
___No ___Yes
If 'Yes', please specify child and condition: _____
_____
_____

27. Does your family regularly engage in family activities? ___No ___Yes
Please describe: _____
_____
_____

28. Have you had trouble with the police? ___No ___Yes

If 'Yes', please specify: _____
_____
_____

29. Has your child had trouble with the police? ___No ___Yes
If 'Yes', please specify: _____
_____
_____

30. Please complete the following:	Child's Mother	Child's Father	Step-Parent, if applicable
Age (present)	_____	_____	_____
Age when first married to First spouse	_____	_____	_____
Total number of marriages	_____	_____	_____
Number of children by previous Marriage	_____	_____	_____
Years of schooling	_____	_____	_____
Occupation	_____	_____	_____

31. How often do you attend religious services? _____

32. Check any of the following which describe your relationship with your current spouse:

_____Stormy	_____Indifferent	_____Unrewarding
_____Disappointing	_____Harmonious	_____Impossible
_____Happy	_____Mistake	_____Understanding
_____Devoted	_____ Wholesome	_____Hopeless
_____Insecure	_____Average	_____Secure

33.I In general, would you say life in your present family is:
_____Excellent _____Good _____Fair _____Poor _____Bad

34.How do you get along with your other child(ren)?
_____Very well _____Fairly well _____Not very well _____Very poorly

35.How well does your spouse or partner get along with your other child(ren)?
_____Very well _____Fairly well _____Not very well _____Very poorly

36.How do you usually punish your child(ren)?
_____Spanking
_____Withholding privileges
_____Privileges
_____Assigning work duties
_____Spanking and withholding
_____Other, specify
_____

37.How does your spouse/partner usually punish your child(ren)?
_____Spanking
_____Withholding privileges
_____Privileges
_____Assigning work duties
_____Spanking and withholding
_____Other, specify
_____

38. Is getting away from your child(ren) -(having time for yourself) a problem for you?
_____No _____Yes

39. Do you feel your life is being disrupted by this child? ___No ___Yes

40. Do you or others feel you or your spouse/partner have a problem with use of drugs or alcohol?
_____No

_____Yes, I do with_____

_____Yes, my spouse does with_____

41. Do you and your spouse disagree frequently about this child?
_____No _____Yes

42. Was your home life a happy one? _____No _____Yes

43. Were you raised by your natural parents? _____Yes _____No
_____Specify by whom: _____

44.How were you usually punished as a child?
_____Spanking
_____Withholding privileges
_____Privileges
_____Assigning work duties
_____Spanking and withholding
_____Other, specify
_____

45.Carefully read the following list, then check up to five (5) traits that were stressed in your home during your childhood.

_____Personal appearance	_____Fun	_____Morality
_____Warmth and affection	_____Religion	_____Pride
_____Power and position	_____Initiative	_____Work
_____Aggressiveness	_____Manners	_____Survival
_____Social obligations	_____Thrift	_____Obedience
_____Cleanliness	_____Honesty	_____Security
_____Independence	_____Ambition	_____Other, specify
_____Generosity	_____Education	_____
_____Quietness	_____Health	

46.Please state here any additional information you feel may be important (include how you think this child could be helped, i.e., counseling with parents and/or teacher, psychological testing, medication, individual therapy, etc.):_____

_____

_____

_____

_____