

PLEASE LIST CHILD(REN) AND SCHOOL(S):

CHILD	GRADE	SCHOOL TEL #	TEACHER	GUIDANCE COUNSELOR

CHILD(REN)'S PHYSICIANS:

NAME	ADDRESS	PHONE
_____	_____	_____
_____	_____	_____

FAMILY HISTORY:

Are there/have there been medical problems with any family member? Yes ___ No ___ If yes, please describe: _____

Are there/have there been psychiatric problems with any family member? Yes ___ No ___ If yes, please describe: _____

Are there/have there been drug or alcohol problems with any family member? Yes ___ No ___ If yes, please describe: _____

Is anyone in your family currently taking prescription medication? Yes ___ No ___ If yes, who, and what medications? _____

DEVELOPMENTAL HISTORY:

I. AT ANY AGE:	Yes	No
Family stresses? (Separation, divorce, relocation, financial)		
Concerns about peer relationships?		
Physical/sexual abuse?		
Problems with controls? Fears?		
Problems keeping immunizations current?		
II. PRE-NATAL/PREGNANCY/POST-NATAL:		
Adopted or foster child?		
Medical/delivery complications?		
Medications?		
Drug or alcohol use during pregnancy?		

	Yes	No
III. PRESCHOOL DEVELOPMENT:		
Any difficulties in achieving motor milestones?		
Speech or language delays?		
Neurological problems?		
Body care difficulties? (Toileting, grooming)		
IV. SCHOOL AGE (5 THROUGH 18 YEARS):		
Learning difficulties?		
Behavioral difficulties?		
Child Study Team evaluation? When?		
Supplemental services? (Resource room, gifted and talented)		
Delayed physical maturation?		
Difficulties in academic achievement?		
Drug or alcohol use?		
Depression or suicidal behaviors?		
Assaultive behaviors?		

HAS YOUR CHILD HAD ANY PREVIOUS TREATMENT SERVICES? IF SO, WITH WHO AND FOR HOW LONG?

PLEASE LET US KNOW HOW YOU LEARNED ABOUT WEST BERGEN.

TO HELP US HAVE A MORE COMPLETE PICTURE OF YOUR CHILD, PLEASE COMMENT ON HIS/HER STRENGTHS AND TALENTS. _____
