Kress Psychological Services, LLC
755 West Carmel Drive, Suite 201
Carmel, Indiana 46032
Telephone: 317-912-1500
Fax: 317-669-0541
www.kresspsychology.com

BACKGROUND AND CURRENT CONCERNS FORM

Patient Name: _____ Date of Birth: _____

Age: _____Gender (M/F):_____ School/Grade: _____

Person completing form: _____

Relationship to Patient (If Patient is minor): _____

Family Information
Mother's Name: _____Mother's Date of Birth: _____

Father's Name: _____Father's Date of Birth: _____

Legal Guardian's Name (If not parent): _____
Legal Guardian's Date of Birth: _____

Parent/Legal Guardian Marital Status: ____Unmarried ____ Married ____ Separated ____Divorced ____Widowed

If parents are divorced, describe the custodial arrangement for the patient:

_____

Stepmother's Name (If applicable): _____
Stepfather's Name (If applicable): _____

Are either parent deceased (Y/N)? ____If yes, mother or father or both? _____

Is the patient adopted (Y/N)? ____ If yes, at what age? _____
Is the patient aware of the adoption (Y/N)? _____ If yes, how long? _____

Has the patient ever been in foster care (Y/N)? _____If yes, when? _____

Does the patient have siblings (Y/N)? ____
If yes, names and ages of siblings: _____

Family Mental Health and Medical History: _____

Medical Information

Name of Patient's Primary Care Doctor: _____

Current Medical Problems for Patient: _____

_____

Past Medical Problems for Patient/Age at Time of Problem: _____

_____

Current Medication for Patient (Name and Dosage): _____

_____

Past Medication for Patient (Name and Dosage): _____

_____

Allergies for Patient: _____

Hospitalizations for Patient (For what and at what age?): _____

_____

Surgeries for Patient (For what and at what age?):_____

_____

Any Serious Accidents/Head Injuries for Patient (Y/N)? ____If yes, list date and details:

_____

History of Tics for Patient (Y/N)? ____ If yes, list date and details:

_____

Hearing or Vision Problems for Patient (Y/N)? ____If yes, please describe:

_____

Eating or Sleeping Problems for Patient (Y/N)? ____If yes, please describe:

_____

Birth and Developmental Information
Length of Pregnancy with Patient: _____

Complications with Pregnancy or Delivery of Patient (Y/N) ____If yes, please describe:

_____

Any Problems with Patient Shortly After Birth (Y/N)? ____If yes, please describe:

_____

Patient's Birth Weight: _____pounds, _____ounces

Patient's Temperament as a Baby: _____

Developmental Milestones (crawling, sitting up, walking, speech and language development, fine motor skills, toilet training):
Within Normal Limits _____
Delays In: _____

Any Involvement for Patient in First Steps Program, Head Start Program, and/or Early Childhood Developmental Program (Y/N)? ____If yes, please describe:

_____

School Information:
Preschool Attendance for Patient (Y/N) ____ If yes, how much time? _____

Patient Age at Start of Kindergarten: _____ Full/Part Day Kindergarten: _____

Patient's Response to Preschool/Kindergarten: _____

Has Patient Repeated a Grade (Y/N)? ____If yes, what grade? _____

Has Patient had an Evaluation through School System (Y/N)? ____If yes, please provide details regarding patient's age, grade, reason for testing, and outcome of testing:

_____

Individual Education Plan (I.E.P.) or 504 Plan for Patient Present (Y/N): _____
If yes, for how long and services provided: _____

_____

Does Patient Receive Tutoring (Y/N)? ____ If yes, for what subject(s) and how often?
_____

Social Information

Concerns about Patient's Social Interactions with Peers or Family Members (Y/N): ____
If yes, please describe: _____

_____

Concern about Drug/Alcohol Usage for Patient (Y/N)? ____
If yes, alone and/or with peers? _____
If yes, please describe concern: _____

_____

Extracurricular Activity for Patient: _____

Hobbies/Interests for Patient: _____

Strengths for Patient: _____

Past Mental Health Care

Patient's Past Mental Health Care (Check all that apply):
____ None
____ Outpatient Therapy Services
____ Outpatient Psychiatric Services
____ Psychological Testing
____ Intensive Outpatient Program
____ Partial Hospitalization
____ Inpatient Hospitalization

For those checked, please provide information (dates of service, reasons for service, diagnoses given, and patient's response to services): _____

_____

_____

Current Concerns for Seeking Services

_____

_____

_____

_____