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Background Information Survey

1. Basic Demographic Information:

Patient Name: _____ Date of Birth: _____

Address: _____

Parent 1: _____ Best Phone: _____

Parent 2: _____ Best Phone: _____

Email: _____ Fax: _____

Billing Address: _____

2. Chief Concerns:

Describe your concerns: _____

3. Past Mental Health Treatments (with dates):

Therapy: _____

Medications: _____

Inpatient stays: _____

4. Medical Information:

Pediatrician/Primary Care: _____ Phone: _____

Medical Conditions: _____

Medications/supplements _____

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Allergies/serious reactions to medications: _____

5. Social Information:

Who lives with the patient (names and ages): _____

Other important people: _____

School name and grade: _____

6. Family History:

Blood relatives with mental health or substance abuse concerns: _____

Family history of medical concerns (seizures, cardiac, liver, kidney, developmental, neurological, diabetes, glaucoma, strokes, etc): _____

Anything else you think is important: _____

