REBOUND MENTAL HEALTH

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CONCERNS CHECKLIST

Patient name: _____ Age:_____ Date: _____

Person filling out form:_____ Relationship to Child:_____

School:_____ Grade:_____

Race:_____

Father: _____
last name first name

Mother: _____
last name first name

Parent relationship: partners married separated divorced widowed

If separated or divorced, provide date:_____
If widowed, date of death: _____

Who suggested that you seek assessment and/or counseling for your child?
School teacher School counselor Myself as a caregiver
Other: _____

Describe the overall problem that led you to seek help for your child:

_____

_____

My child has difficulty with a relationship in our family (parent, sibling, parent's significant other or new husband or wife): Yes No
If yes, who:_____

I have reason to suspect my child has been abused (emotionally, sexually and/or physically):
Yes No
Please Explain:_____

Describe your child's school experience:

_____
_____

Describe your child's interactions with parents:

_____
_____
_____

Describe your child's interactions with siblings:

_____
_____

Describe your child's ability to complete tasks and follow directions:

_____
_____

I would describe my child as being: Independent Dependent
Please, explain:_____

My child appears to have high levels of stress: Yes No
If yes, please explain:_____

Describe your child's sleep patterns:

_____
_____

Describe your child's eating patterns:

_____
_____

Describe your child's physical activity level:

_____
_____

Medical History

Birth: Duration of labor:_____
Type of delivery: _____
Difficulties:_____
How soon did the mother see baby? _____
Birth weight: _____

Infancy: Age of weaning: _____
Feeding problems? _____

Approximate age of walking:_____
Approximate age of talking: _____

Sleep problems? Yes No
If yes, please explain:_____

Any behavior such as head banging, rocking, etc.? Yes No
If yes, please explain:_____

Does your child have difficulty separating from his/her parents? Yes No
If yes, please explain:_____

Has your child had any severe, long-term illnesses or accidents? Yes No
If yes, please explain:_____

Is your child on any medication? Yes No
If yes, please list:_____

Does your child have any digestive problems? Yes No
If yes, please explain:_____

Does your child have any allergies? Yes No
If yes, please explain:_____

Does your child have any physical pain? Yes No
If yes, please explain:_____

Does your child ever appear disoriented or dizzy? Yes No
If yes, please explain:_____

Family Mental Health History

The following is to provide information about your family history. Please mark each as yes or no. If yes, please indicate family member affected.

Autism Spectrum	Yes	No	_____
Attention Deficit	Yes	No	_____
Depression	Yes	No	_____
Anxiety Disorder	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Panic Attacks	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disability	Yes	No	_____
Trauma History	Yes	No	_____
Domestic Violence	Yes	No	_____
Obesity	Yes	No	_____
Obsessive Compulsive Behavior	Yes	No	_____
Schizophrenia	Yes	No	_____

This is a confidential patient record.