Kemper & Associates Neuropsychological Services

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Background Information (for minors)

When evaluating minors it's important to have as much information about the household in order to properly assess your minor. Please make sure background information for all parents/guardians is also completed on a separate form.

Yes _____ No _____ Parents/Guardians completed background information for adults?

Name ____ Today's Date __________________________
Age ___________ Grade Level ____________________ Date of Birth _______________________________
School Attending ____
After School Jobs ____
Hobbies Sports ____
Left or Right Handed:

Family Status
Mothers Name _____________________________ Age ___________ Occupation _______________________
Fathers Name ______________________________ Age ___________ Occupation _______________________
Legal Guardian (If not parent) ____
Parents Currently: Married ________ Separated ________ Divorced ________ Not Married ________
If Divorced who has custody: Mother ________ Father ________ Both ________ Other __________
Both parents living: Yes _______ No ________ Explain ____
List everyone in household
____
____
Sister(s) ages __________________________________ Brother(s) ____________________________________

Health Status
Current of Chronic Health Problems ____
____
Current Medications, including over-the-counter ____
____

Mental Health Status
Previous Counseling (including dates & places) ____
____
Previous Hospitalization for emotional or substance abuse problems ____________________________
____
History of medications for emotional/ substance abuse problems ______________________________
____

Which of the following are of concern to you at this time? (Check all that apply)
Emotional Health ______ Abuse/ Violence _________ Behavior Problems ______
Substance Use/Abuse____ Health-Related __________ Social Relationships _____
Suicide Risk ___________ Eating Disorder _________ Family Issues __________
School Problems _______ Other Issues ______________________________________

Current Substance Use (0=no use, 1=occasional, 2= moderate, 3=heavy, 4 addiction, 5= currently in treatment.)
Alcohol ______ Tobacco ______ Caffeine ______ Illicit Drugs (specify) __________________________
Past Use of Drugs (specify) ____
Did you request evaluation services? Yes __________ No __________
If No, Who is requesting you have an evaluation? ____
Why is this person requesting you attend counseling? ____