



Address: _____

If participant is under 18; please provide custody information: _____

DOB: _____ GENDER: ____ ETHNICITY: _____ Is English your preferred Language: Yes No

Physically challenged (wheelchair, hearing, visual, etc.)? Yes No If yes, please specify: _____

1. Has participant ever been in therapy? Yes, Currently Yes, Previously No

(How long, with whom, reason for treatment, medication, etc.?)

2. Has participant ever been hospitalized for being a danger to him/herself or others? Yes No

If yes, describe:

3. Is participant taking psychotropic medication(s)? Yes No

If yes, describe:

4. Is participant having difficulty in any of the following areas: Anger, eating, sleeping, hygiene? Yes No

If yes, describe:

5. Have there been any recent changes in participant's behavior? Yes No

If yes, describe:

6. Has the participant ever attempted to hurt themselves or others? Yes No

If yes, describe:

7. Has the participant experienced any recent traumatic events (abuse, violence, , etc.)? Yes No

If yes, describe:

8. Is there any current or past involvement with DCFS? Yes No

If yes, describe: