



Building Resilience, Self-Esteem and Healthy Relationships in the Youth of Today

Background Information Form

In order to determine the suitability of the *Kids and Teens Group* workshops in addressing the needs of your child / adolescent, we need to receive the following information:

(Information obtained is strictly confidential and is only used by the Kids & Teens Group to assess suitability and address psychological needs)

NAME: _____

D.O.B: _____ GRADE: _____ AGE: _____ GENDER: _____

PARENTS / CARERS _____

ADDRESS: _____

HOME PHONE: _____ MOBILE: _____

EMAIL: _____

SIBLINGS: _____

Age of Siblings: _____

Sibling Mental Health Conditions (eg ADHD): _____

FAMILY MEMBER/S CURRENTLY LIVING WITH CHILD / ADOLESCENT:

LANGUAGE SPOKEN BY CHILD / ADOLESCENT: _____

MEDICAL CONDITIONS: _____

ALLERGIES: _____

MEDICATION: _____

SCHOOL: _____

Does your child / teen have any learning difficulties (reading or writing) that may impact on his/her participation in the group? Does he/she require any visual or hearing aids?

Has your child / adolescent previously received any assessment/s or therapy by a:

Developmental Paediatrician

Speech Therapist

Occupational Therapist

Psychologist / Counsellor

Other _____

Specialist / Centre name:	
Referral Date:	
Reason for Referral:	
Recommended Treatment:	
Treatment Duration:	

Please indicate the areas of concern (eg. anxiety, stress or anger management, self esteem, social ability etc) you have regarding your child / adolescent?

Please indicate if there are any family circumstances that will assist us in understanding the context of your child / teen and his/her needs (history of mental illness etc).

Please indicate if there is any additional information that you want to include regarding the participation of your child / adolescent in the Kids and Teens Group.

Thank you for completing this Background Information Form. Please sign below to confirm that the information provided is correct, truthful and fully inclusive of all behavioural and health conditions. This signature also gives CONSENT for your child / adolescent to participate in the *Kids and Teens Group* workshops:

Name: _____ Signature: _____ Date: _____

Please return this form to Yana Belogiannis via one of the following methods:

Email: yana@kidsandteens.com.au

Fax: 9587 6536 or

Postal Address: P.O Box 4164, Kingsway West NSW 2208