



Family Background

CHILD'S NAME: _____ BIRTH DATE: _____

What are the most important aspects of your child's life that you want us to know about?
(Please include family structure, culture and strong interest)

DO YOU IDENTIFY WITH A PARTICULAR ETHNIC GROUP? PLEASE CHECK ALL THAT APPLY AND INDICATE COUNTRIES OF FAMILY'S ORIGIN.

- | | |
|--|--|
| <input type="checkbox"/> Asian American (countries) | <input type="checkbox"/> Middle Eastern (countries) |
| <input type="checkbox"/> Black/ African American (countries) | <input type="checkbox"/> Pacific Islander (countries) |
| <input type="checkbox"/> Caucasian/ European American (countries) | <input type="checkbox"/> South Asian American (countries) |
| <input type="checkbox"/> Latino/ Hispanic American (countries) | <input type="checkbox"/> Native American (tribal affiliation - optional) |
| <input type="checkbox"/> International - People who do not hold American citizenship or who are not permanent residents of America (countries) | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Multiracial American - People who identify with more than one ethnic race/ heritage (ethnicity/ countries) | _____ |

DO YOU IDENTIFY WITH A PARTICULAR RELIGIOUS GROUP? PLEASE CHECK ALL THAT APPLY.

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Christianity | <input type="checkbox"/> New Thought Movement | <input type="checkbox"/> Buddhism |
| <input type="checkbox"/> No religion | <input type="checkbox"/> Sikhism | <input type="checkbox"/> Hinduism |
| <input type="checkbox"/> Judaism | <input type="checkbox"/> Islam | <input type="checkbox"/> Baha'I Faith |
| <input type="checkbox"/> Native American Religious Practices | <input type="checkbox"/> Other (please specify) _____ | |

LANGUAGES SPOKEN AT HOME: PLEASE CHECK ALL THAT APPLY

- | | | | |
|----------------------------------|---------------------------------|-------------------------------------|---|
| <input type="checkbox"/> English | <input type="checkbox"/> French | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> German | <input type="checkbox"/> Khmer | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Hmong | <input type="checkbox"/> Italian | |

IS YOUR CHILD RECEIVING OR HAVE RECEIVED IN THE PAST ANY THERAPY FOR THE FOLLOWING ISSUES:

- | | | |
|--|---|---|
| <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Visual impairment | <input type="checkbox"/> ADHD | <input type="checkbox"/> Maintenance care diseases |
| <input type="checkbox"/> Orthopedic handicaps | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Mentally disabled/ developmentally delayed |
| <input type="checkbox"/> Behavioral | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Speech & Language disorders | <input type="checkbox"/> Autism, spectrum disorders | |