

Patient Name _____

SPIRITUAL BACKGROUND

List past and present religious affiliation, involvement in church, guiding spiritual principles:

What particular spiritual/religious issues would you like help addressing with your child?

What spiritual/religious resources does the child/teen have available?

Prayer	Faith community	Spiritual friend	Spiritual reading
Church Attendance		Other _____	

Would you like to discuss any of these spiritual issues with someone? YES NO

CULTURAL:

Ethnicity/race: _____

Are there any family/cultural values or traditions we need to know about? (Foods, family organization, customs, etc.)

STOP – The following information will be completed by the provider.

CASE FORMULATION (include theory for cause of identified problems)

ATTRIBUTES THAT ENHANCE TREATMENT _____

DEFICITS THAT IMPEDE TREATMENT _____

DMS-IV DIAGNOSIS

Axis I _____ Axis II _____ Axis III _____

Axis IV	Family	Social	Educational
	Occupational	Housing	Economic
	Health Care	Legal	Other _____

Axis V Current _____ Highest in the past year _____
(insert #, not range)

Signature _____ Date _____