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CHILD HISTORY

Child's Name: _____ Nickname: _____ Date of Birth: __/__/__

Age: _____ Gender: ___ Male ___ Female Parent/Guardian: _____

Address: _____ City: _____ Zip: _____

Phone #: _____ Work #: _____

School: _____ Grade: _____ Phone: _____ Principal: _____

Teacher: _____ Special Ed.: _____ Counselor: _____

List previous schools attended with dates: _____

Foster care: _____ Adopted: _____ Age Adopted: _____

Referred by: _____ Reason: _____

Family Physician or Medical Group: _____ Address: _____

Phone: _____ Fax: _____ Nurse: _____

Are there problems in the family that may relate to the child's problem? YES...NO

If yes, specify: _____

Any history of mental, emotional or neurological illness such as depression, anxiety, hyperactivity, learning disability or drug/alcohol problems in either parent's family? Please indicate whom, what type of problem and with what result:

If parents are not living together, please describe amount and frequency of contact with each parent.

BIRTH & DEVELOPMENT

Was the pregnancy or birth complicated? If yes, please describe:

Any problems during the first year (i.e. colic, feeding problems, sleep problems)?

Age for milestones: Sat by self _____ Walked alone _____ Said first word _____ Spoke in sentences _____

Toilet Trained: Urine day _____ Urine night _____ Bowel day _____ Bowel night _____

To whom was the child most attached during his/her infancy? _____

What events in raising your child stand out as unusual or distinguished him/her from other children?

MEDICAL HISTORY

Any significant events in the child's medical history (i.e. illnesses, injuries, surgeries):

Other health problems: _____

How is your child's vision/hearing? _____ Medications? _____

Has your child ever been physically or sexually abused? _____ When? _____

Child's current academic achievement is (circle one):

*Below Average *Average *Above Average *Don't Know

Child's intellectual ability is (circle one):

*Below Average *Average *Above Average *Don't Know

Psychologist: _____ Phone: _____

Social Worker: _____ Phone: _____

Probation Officer: _____ Phone: _____

List all persons now living in the household and then list others who have lived there during the child's lifetime.

Name	Relationship to child	Age	Occupation
1. _____			
2. _____			
3. _____			
4. _____			

Any other marriages for either parent? _____ Dates: _____

Attitude of sibling(s) towards the child: _____

Symptom Checklist (Please check all that apply):

-
- | | | |
|--|--|---|
| 1. <input type="checkbox"/> Attention problems | 17. <input type="checkbox"/> Low energy | 33. <input type="checkbox"/> Truant from school/home |
| 2. <input type="checkbox"/> Concentration problems | 18. <input type="checkbox"/> Social Withdrawal | 34. <input type="checkbox"/> Learning problems |
| 3. <input type="checkbox"/> Does not listen | 19. <input type="checkbox"/> Suicidal thoughts/threats | 35. <input type="checkbox"/> Messy |
| 4. <input type="checkbox"/> Fails to finish tasks | 20. <input type="checkbox"/> Anxiety/panic | 36. <input type="checkbox"/> Tics |
| 5. <input type="checkbox"/> Often loses things | 21. <input type="checkbox"/> Fear of Dying | 37. <input type="checkbox"/> Dislikes school |
| 6. <input type="checkbox"/> Easily distracted | 22. <input type="checkbox"/> Fears/phobias | 38. <input type="checkbox"/> Wets the bed at night |
| 7. <input type="checkbox"/> Forgetful | 23. <input type="checkbox"/> School stress | 39. <input type="checkbox"/> Daytime wetting |
| 8. <input type="checkbox"/> Fidgets or squirms | 24. <input type="checkbox"/> Overly clean | 40. <input type="checkbox"/> Bowel accidents |
| 9. <input type="checkbox"/> Runs excessively | 25. <input type="checkbox"/> Physical complaints | 41. <input type="checkbox"/> Sexual misbehavior |
| 10. <input type="checkbox"/> Cannot play quietly | 26. <input type="checkbox"/> Fights/temper display | 42. <input type="checkbox"/> Fails to adjust with other children. |
| 11. <input type="checkbox"/> Talks excessively | 27. <input type="checkbox"/> Steals | 43. <input type="checkbox"/> Unusual mannerisms |
| 12. <input type="checkbox"/> Blurts out answers | 28. <input type="checkbox"/> Alcohol/drug use | 44. <input type="checkbox"/> Prefers younger children |
| 13. <input type="checkbox"/> Difficulty waiting turn | 29. <input type="checkbox"/> Lies/boastful | 45. <input type="checkbox"/> Anger control problems |
| 14. <input type="checkbox"/> Depressed/discouraged | 30. <input type="checkbox"/> Selfish | 46. <input type="checkbox"/> Cruel to others |
| 15. <input type="checkbox"/> Eating disturbances | 31. <input type="checkbox"/> Disobedient/defiant | |
| 16. <input type="checkbox"/> Sleep disturbance | 32. <input type="checkbox"/> Cruel to animals | |

Please describe above checked items: _____

Describe what your child likes to do for fun: _____

What situations, relationships, or events tend to be most difficult or upsetting for your child: _____

List your child's talents and skills: _____

We appreciate the effort which you have given to filling out this questionnaire. Your answers help to evaluate your child in a more efficient manner. Please add any additional comments which might be helpful: _____

DATE

SIGNED (Patient 12+ years)

DATE

SIGNED (Parent/Guardian)