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Licensed Clinical Professional Counselor

# Springfield Psychological Center, LLC

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**Jeanette Hoelzer, LCPC**
Licensed Clinical Professional Counselor

**Bethany Bilyeu, Psy.D.**
Licensed Clinical Professional Counselor

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Licensed Clinical Social Worker

## CHILD HISTORY

Child's Name:_____ Nickname: _____ Date of Birth: ___/___/____

Age: _____ Pronouns: _____ 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?

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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: _____

Any prior mental health hospitalizations:

_____

_____

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

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)