CHILD HISTORY FORM

Today's date:

Name: **Age:** **Birthdate:**

Address:

Phone Numbers (circle preferred # for me to use):

Parent's email:

Parent's Names and Marital/Relationship Status:

Parent's Address:

Education:

Occupation:

EMERGENCY CONTACT INFORMATION:

Name:

Contact Number (s):

Address:

Under what circumstances can this person be contacted (check all that apply):

- **Call in an Emergency only**
- **Can use to relay scheduling information**
- **Can all them if therapist can't find patient and needs to relay info**
- **Can share clinical information at therapist's discretion**
- **Please do NOT share clinical information without specific patient permission**

<u>INSURANCE INFORMATION</u>:

Company: **ID:** **Group #**

Effective Date

Insured name:

Contact information:

Authorization number:

CHILD/ADOLESCENT HISTORY

Child's Name: _____ MRN: _____

Birth Date: _____ Grade: _____ Male or Female

PRESENTING PROBLEM(S):

What type of problems is your child having at home?

_____

_____

_____

How old was she/he when these problems started? _____

Have there been any changes? If so, when? _____

_____

_____

What type of problems is your child having at school?

_____

_____

_____

How old was she/he when these problems started? _____

Have there been any changes? If so, when? _____

_____

Have there been any incidents in your child's life that you believe have caused her/his problems or that have caused changes in her/his behavior? _____

_____

_____

Has your child ever received counseling for these problems? If so, when and where?_____

_____

Has your child ever received medication for these problems? If so, when and what kind? _____

_____

What other types of treatment has your child received for these problems? _____

_____

Has your child ever been diagnosed with ADHD, a learning disability, or any emotional problems? If yes, when? _____

_____

Is there any history of the following in the child's family?

Learning problems	Yes _____	No _____	Describe _____
Dyslexia	Yes _____	No _____	Describe _____
Speech problems	Yes _____	No _____	Describe _____
Mental retardation	Yes _____	No _____	Describe _____
Hyperactivity	Yes _____	No _____	Describe _____
Substance abuse	Yes _____	No _____	Describe _____
Schizophrenia	Yes _____	No _____	Describe _____
Depression	Yes _____	No _____	Describe _____
Anxiety	Yes _____	No _____	Describe _____
Emotional problems	Yes _____	No _____	Describe _____
Eating disorders	Yes _____	No _____	Describe _____

FAMILY/SOCIAL BACKGROUND:

Mother's Name: _____ Age: _____

Education: _____ Occupation: _____

Father's Name: _____ Age: _____

Education: _____ Occupation: _____

Is your child:		Are the parents:			
Adopted	_____	Married	_____	How long?	_____
Stepchild	_____	Separated	_____	How long?	_____
Foster child	_____	Divorced	_____	How long?	_____
Biological child	_____	Remarried	_____	How long?	_____

List the name, age, and relationship to your child of all persons living in the home:

Name	Age	Relationship to child

If the child does not live with both biological parents, how often does she/he see the parent who does not live in the home?

More than once a week _____ Once a week _____

One or more times per month _____ Every few months _____

Less than once a year _____ Every few years _____

Never _____

Does the child have siblings who do not live in the home? What are their names and ages? _____

_____

How does your child get along with her/his:

Mother _____

Father _____

Sibling(s) _____

Other family members _____

Pet(s) _____

Do any of the child's close relatives suffer from medical problems? If yes, who are they and what problems do they have? _____

_____

Has the child lost any close relatives? If yes, who? _____

_____

When your child misbehaves, how do you respond? _____

_____

How does her/his other parent/caregiver respond? _____

_____

Who usually disciplines? _____ How? _____

_____

Is discipline effective? _____

What activities/hobbies does your child enjoy? _____

_____

Does your child prefer to play alone, with friends, with siblings, or with adults?

_____

Where does your child play most often? _____

How much television does your child usually watch each day? _____

Does your child belong to any organized groups (ex. Boy Scouts)? _____

_____

Does your child play organized sports? _____

When interacting with peers, would your child be best described as:

Shy _____ or Outgoing _____

Friendly _____ or Aggressive _____

Leader _____ or Follower _____

What do you feel are your child's best qualities? _____

_____

_____

EDUCATION:

Name of your child's school: _____

Teacher: _____ Counselor: _____

Has your child changed schools recently? Yes _____ No _____

If yes, when and why? _____

What were your child's grades on her/his last report card? _____

_____

Has your child ever repeated any grades? _____ Which grades? _____

Has your child ever been enrolled in any special education program? _____

If yes, when? _____ What type of program? _____

_____

Has your child ever received any tutoring or special services outside of school?

If yes, when? _____ What type of program? _____

_____

What subjects is your child good at in school? _____

What subjects does your child have problems with? _____

What kind of learning problems does your child have? _____

_____

What kind of behavior problems does your child have at school? _____

_____

Has your child ever been suspended from school? If yes, why? _____

_____

DEVELOPMENTAL/MEDICAL HISTORY:

Did the mother have any of the following problems during her pregnancy with this child?

High blood pressure	_____	Anemia	_____
Excessive sleepiness	_____	Tension	_____
Swelling	_____	Dizziness	_____
Headaches	_____	Toxemia	_____
Fainting spells	_____	Bleeding	_____
Morning sickness	_____	Staining	_____
Viral illness	_____	Medication	_____
Rh Incompatibility	_____	Smoked	_____
Alcohol	_____	Drugs	_____

Other _____

How much weight did the mother gain during pregnancy? _____

Which week/month of pregnancy was birth? _____

Was labor induced? Yes _____ No _____

Was delivery vaginal or Cesarean? _____

Were forceps used? Yes _____ No _____

How much did the baby weigh at birth? _____ pounds, _____ ounces

Did the baby have breathing problems? Yes _____ No _____

Was the cord around the baby's neck? Yes _____ No _____

Was the baby's color normal? Yes _____ No _____

Was the baby placed in an incubator or special crib? Yes _____ No _____

How long? _____ Why? _____

Did the baby receive:

Oxygen? Yes _____ No _____ How long? _____

Transfusion? Yes _____ No _____ How long? _____

Phototherapy (lights)? Yes _____ No _____ How long? _____

How long did the baby stay in the hospital? _____

Which of the following describe your child's behavior as a baby?

Frequently smiled	_____	Frequently cried (no reason)	_____
Easy to soothe	_____	Difficult to soothe	_____
Cried when wet	_____	Cried when hungry	_____
Enjoyed being held	_____	Enjoyed being rocked	_____
Regular feeding	_____	Difficult to feed	_____
Regular sleep pattern	_____	Irregular sleep pattern	_____
Fussy	_____	Very active	_____
Very quiet	_____	Failed to gain weight	_____

At what age did your child:

Sit up without help	_____	Crawl	_____
Stand without help	_____	Walk without help	_____
Say her/his first word	_____	Put words together	_____
Toilet train (daytime)	_____	Toilet train (night)	_____

Does your child seem to speak as well as other children of the same age? _____

_____

Has your child ever had any of the following problems?

Pronouncing words	_____	Small vocabulary	_____
Not speaking	_____	Stuttering	_____

When was your child's last physical examination? _____

Has your child had her/his eyes examined? Yes _____ No _____

When? _____ Results of exam _____

Has your child had her/his hearing tested? Yes _____ No _____

When? _____ Results of exam _____

Are your child's immunizations up-to-date? Yes _____ No _____

Does your child have any allergies? Yes _____ No _____

What kind? _____

Has your child ever had any head injuries? Yes _____ No _____

Describe _____

Did she/he lose consciousness? Yes ____ No _____ How long? _____

Has your child had any accidents that required medical attention?

Yes _____ No _____ Describe _____

Has your child ever been hospitalized? Yes ____ No _____

Why? _____

Does your child have a history of:

Ear infections	_____	Asthma	_____	Allergies	_____
Tubes inserted	_____	Seizures	_____	Diabetes	_____
Frequent colds	_____	Other chronic illness	_____		

What medications is your child currently taking? _____

_____

In past years, what medications has your child taken for more than one week? ___

_____