Please complete all information on this form and bring it to your first visit.

# Child Demographic Information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Child’s Name |  | Gender |  | Age |  | DOB |   |
| 2. Natural Child  |  c Yes  | c No  |  | If adopted, at what age |  | Foster since |  |
| 3. Parent’s Names (include step-parents, foster parents, inc.)  |  |
|  |
|  |
| 4. Comments about custody and visitation (if applicable):  |  |
|  |
|  |
| 5. Primary reason you are concerned about your child?  |  |
|  |
|  |

# SYMPTOM/PROBLEM CHECKLIST

Check any symptom that is a concern and please note how long has it been a problem?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | c Sleep problems |  |  | c Morbid thoughts  |  |
|  | c Lack of interest in activities |  |  | c Suicidal thoughts or threats  |  |
|  | c Unassertive |  |  | c Suicidal plans / attempts  |  |
|  | c Fatigue/low energy |  |  | c Mood swings  |  |
|  | c Concentration problems |  |  | c Depression  |  |
|  | c Appetite/weight changes  |  |  | c Changed level of activity |  |
|  | c Withdrawal  |  |  | c Cries easily  |  |
|  | c Forgetful/memory problems |  |  | c Talks excessively / interrupts  |  |
|  | c Short attention span |  |  | c Easily distracted  |  |
|  | c Aggressive behavior |  |  | c Irritable  |  |
|  | c Can’t sit still |  |  | c Impulsive  |  |
|  | c Not interested in peers |  |  | c Difficulty following rules  |  |
|  | c Picked on / bullied by peers |  |  | c Problem completing schoolwork  |  |
|  | c Excessive worry / fearfulness |  |  | c Nightmares  |  |
|  | c Anxiety or panic attacks |  |  | c Frequent tantrums  |  |
|  | c Social fears, shyness |  |  | c Resistive to change  |  |
|  | c Separation problems |  |  | c School refusal  |  |
|  | c Bedwetting / soiling |  |  | c Perfectionism  |  |
|  | c Headaches, stomachaches |  |  | c Odd hand / motor movements  |  |
|  | c Odd beliefs / fantasizing |  |  | c Hallucinations  |  |
|  | c Lying |  |  | c Stealing  |  |
|  | c Trouble with the law |  |  | c Being destructive  |  |
|  | c Running away |  |  | c Fire setting  |  |
|  | c Truancy, skipping school |  |  | c Hurting others / fighting  |  |
|  | c Hurting others sexually |  |  | c Acts as if has no fear  |  |
|  | c Alcohol / drug use |  |  | c Short tempered  |  |
|  | c Argumentative / defiant |  |  | c Easily annoyed / annoys others  |  |
|  | c Swears |  |  | c Discipline problem  |  |
|  | c Blames others for mistakes |  |  | c Angry and resentful  |  |

# Siblings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | First Name – Last Name | Gender | Age | Relationship to child (full, step, half, foster)  |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |
| 6.  |  |  |  |  |

# SCHOOL HISTORY

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. | Present School: |  | Grade:  |  | Teacher: |  |
| 2. | Has child ever repeated any grade? |  c Yes  | c No  |
| 3. | Is child in special education services? |  c Yes  | c No  | what kind? |  |
| 4. | Please describe academic or other problems your child has had in school |  |
|  |  |

# CHILD’S DEVELOPMENTAL AND MEDICAL HISTORY

|  |
| --- |
| Pregnancy  |
|  | Mother used during pregnancy: | c Alcohol | c Drugs | c Cigarettes |  |
|  | Delivery: | c Normal  | c Breech  | c Cesarean  | c Transectional  |
|  |  | c Full-term | c Premature  |  if premature, number of weeks |  |
|  | Birth Weight: |  |  |  |  |
|  | Problems at birth: (for example: infant given oxygen, blood transfusion, placed in an  |
| Incubator, etc) |  |
|  |  |
| Developmental History |
|  | State approximate age when child did the following:  |
|  |  | Walked alone |  |  |  |
|  |  | Said first word  |  |  |  |
|  |  | Used 2-word phrases |  |  |  |
|  |  | Understood and followed simple directions |  |  |  |
|  |  | Reasonably well toilet trained |  |  |  |
|  | Excessive crying c |  Rarely cried c |  |  |
|  | In the first two years, did your child experience:  |
|  |  | c Separation from mother | c Neglect |
|  |  | c Out of home care | c Chronic pain |
|  |  | c Disruption in bonding | c Chronic Illness |
|  |  | c Depression of mother | c Parental Stress  |
|  |  | c Abuse |  |  |  |
| Health History of Child |
| Child’s Doctor: |   |
| Date of last physical exam: |  |
| Vision problems? |  c Yes  | c No  |  |
| Hearing problems?  |  c Yes  | c No  |  |
| Dental problems? |  c Yes  | c No  |  |
| Any head injuries or loss of consciousness?  |  c Yes  | c No  |  |
| Child’s history of serious illness, injury, handicaps, or hospitalization? |  c Yes  | c No  |
|  | describe and give dates  |  |
| Is your child currently taking any medications? |  c Yes  | c No  |  |
|  | name medications  |  |
| List any medicines previously used for emotional problems: were they helpful?  |
|  |
| Allergies to drugs or medicines? |  c Yes  | c No  |  |
| (list) |  |
| Allergies to any foods? |  c Yes  | c No  |  |
| (list) |  |
| Are there any foods that you limit or do not give this child? |  c Yes  | c No  |  |
| (list) |  |
| Allergies to environmental conditions? |  c Yes  | c No  |  |
| (list) |  |
| Does anyone in the household smoke? |  c Yes  | c No  |  |
| About how many hours per day does this child engage with electronic media (i.e., iPad, video  |
| games, TV, etc.) |  |
| Are you afraid someone you know may injure/harm this child? |  c Yes  | c No  |  |
| **National Domestic Violence Hotline 1-800-799-7233**  |
| Does this child have a Health Care Directive? |  c Yes  | c No  |  |
| If yes, please list where (clinic)  |  |
| Any previous psychological or psychiatric treatment? |  c Yes  | c No  |  |
|  | Whom/where |  | when |  |
| Any previous testing (school/psychological)? |  c Yes  | c No  |  |
|  | Whom/where |  | when |  |
| Do you think your child’s use of chemicals is a problem? |  c Yes  | c No  |  |
| Type:  |  c Alcohol  | c Marijuana  | c Other drugs  |  |
|  |
| Comments: |   |
|  |
|  |

# Family History:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chemical use (now & past): |  c Yes  | c No  | Which parent |  |
|  | Type: c Alcohol | c Marijuana  | c Other drugs |  |
| List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bipolar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):  |
|  |
|  |
| Has child witnessed domestic violence? |  c Yes  | c No  |  |
|  | Specify: |  |
| How is your child disciplined? Please list each method and frequency of use: |  |
|  |
|  |

# LIFE STRESSORS/TRAUMA HISTORY

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Has your child been verbally abused? |  c Yes  | c No  | c Suspected.  |
|  | Specify: |  |
| 2. Has your child been physically abused?  |  c Yes  | c No  | c Suspected |
|  | Specify: |  |
| 3. Has your child been sexually abused? |  c Yes  | c No  | c Suspected |
|  | Specify: |  |
| 4. Other stressors or traumas? |  |
|  |
|  |
|  |
| What are your child’s strengths?  |  |
|  |
|  |
| Any additional comments or information that would be helpful to us?  |  |
|  |
|  |
| Signature of person completing form / relationship to client: |  |
|  |
|  |  |  |  |  |
| Signature |  | Date |  |  |
|  |  |  |  |  |
|  |  |  |
| Printed Name |  | Relationship |  |
|  |  |  |  |