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Check one: rev 1-7-20

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CHILD HEALTH HISTORY FORM

Today's date: _____

Child's name: _____Age: ____ Date of birth: _____

Name of person completing this form: _____

Relationship to child: (Mother?) _____ (Father?) _____ (Other?) _____

Name of pediatrician: _____

Pediatrician's Phone number: _____ Fax:_____

Who is requesting or recommending these services for your child? (circle all that apply)

Parent **Therapist** **Physician**

Pediatrician **Psychiatrist** **School**

Attorney **DFCS** **Court** **Other**? _____

What is the reason for the visit today? _____

_____

What are your primary concerns about your child? _____

_____

_____

CHECK THE FOLLOWING THAT APPLY:

__ Depression	__ Anxiety	__ Self-harming behavior
__ Mood swings	__ Low motivation	__ Low self-esteem
__ Suicidal ideation	__ Hallucinations	__ Bizarre or strange behavior
__ Hyperactivity	__ Difficulty focusing	__ Difficulty concentrating
__ Aggression	__ Anger	__ Stealing
__ Defiance	__ Lying	__ Hoarding food
__ Temper tantrums	__ Sexual acting out	__ Attention-seeking
__ Developmental delays	__ Language delay	__ Learning problems
__ Poor social skills	__ Poor eye contact	__ Bed wetting
__ Sensory concerns	__ Poor memory	__ Organization problems
__ Eating disorder symptoms	__ Low frustration tolerance	
__ Motor skills or coordination problems		

DEVELOPMENTAL HISTORY

Length of pregnancy: _____ Child's weight at birth: _____

Any problems with pregnancy or delivery? (circle one) **YES** **NO** **DON'T KNOW**
If yes, please explain: _____

_____

Any known alcohol or substance abuse during pregnancy? **YES** **NO** **DON'T KNOW**
If yes, please describe: _____

Any health problems at birth? **YES** **NO**
If yes, describe: _____

_____

Was infant hospitalized for any length of time after birth? **YES** **NO**
If yes, briefly describe: _____

Any delays with developmental milestones (talking, walking, potty training, etc.)?
YES **NO** If yes, please explain: _____

_____

Has your child ever received any of the following?

	Currently?	In the Past?	If yes, describe:
Speech Therapy			
Physical Therapy			
Occupational Therapy			

MEDICAL HISTORY

When was your child's last visit to the pediatrician? _____
Any concerns at that time? **YES** **NO**
If yes, please explain: _____

_____

Does your child have hearing or vision problems? **YES** **NO**
If yes, are they corrected (with glasses, contact lenses, hearing aids, etc.)? _____

Has your child ever been hospitalized for general medical reasons? **YES** **NO** **DON'T KNOW**
If yes, reason and approximate date(s): _____

_____

Has your child ever had surgery? **YES** **NO** **DON'T KNOW**
If yes, briefly describe: _____

_____

Does your child have any chronic illness (such as diabetes, asthma, etc.)? **YES** **NO**
If yes, briefly describe: _____

_____

Does your child have any medication, food, or other allergies? **YES** **NO** **DON'T KNOW**
If yes, briefly describe: _____

Does your child ***currently*** take any prescription medications (non-psychiatric)? **YES** **NO**
If yes, medication names: _____

Has your child ever had any head injuries? **YES** **NO** **DON'T KNOW**
If yes, briefly describe: _____

Has your child ever had any other major injuries? **YES** **NO** **DON'T KNOW**
If yes, briefly describe: _____

Does your child have any appetite problems or problematic weight gain or weight loss?

YES NO DON'T KNOW

If yes, briefly describe: _____

Does your child have any sleep problems or nightmares? **YES NO**

If yes, briefly describe: _____

FAMILY HISTORY

Names & ages of child's siblings: _____

Who currently lives in the home? _____

Check any family crises or problems that have occurred in child's household:
(describe further in the comments section below as needed)

___Separation/divorce of parents
___Death of a family member
___Death of a pet
___Serious illness of a family member
___Other _____

____Parent's new job
____Move to a new home
____Birth of sibling
____Addiction of family member

Comments:

Does your child have opportunities to play with other children? _____

How does you child get along with other children? _____

What are your child's favorite activities? _____

EDUCATIONAL HISTORY

Name of child's school: _____

What grade is he/she in? _____ Current or most recent grades: _____

Has your child repeated any grades? (if yes, which ones?) _____

Is your child receiving special education services? **YES NO**

If yes, for what reason? (circle all that apply) **behavioral emotional educational**

Any major school discipline (suspensions, expulsions) or behavior problems in school? **YES NO**

If yes, briefly describe: _____

MENTAL HEALTH HISTORY

Has your child ever received a mental health diagnosis in the past? **YES** **NO**
If yes, what diagnosis? _____

Has your child ever seen a psychiatrist for psychiatric medication? **YES** **NO**
If yes: Name of psychiatrist ? _____ When? _____

Is your child ***CURRENTLY*** taking psychiatric medications? **YES** **NO**
If yes, name(s) of medication(s): _____

Has your child taken any other psychiatric medication in the past? **YES** **NO** **DON'T KNOW**
If yes, names of medications and dosages (if known): _____
_____

Has your child ever had a psychological evaluation? **YES** **NO** **DON'T KNOW**
If yes, when and what was the diagnosis? _____

Is your child ***CURRENTLY*** receiving therapy or counselling for emotional or behavioral problems?

(circle all that apply)	Provider or Agency	Date Started	Frequency	For what issues?
Individual				
Group				
Family				
Other				

Has your child received therapy or counseling in the ***PAST*** for emotional or behavioral problems?

(circle all that apply)	Provider or Agency	Date Started	Date Stopped	Why did the therapy stop?
Individual				
Group				
Family				
Other				

Has your child ever been admitted to a psychiatric hospital? **YES** **NO**
If yes, please list date(s) and name(s) of hospitals: _____
_____

Has your child ever had suicidal thoughts or made suicidal threats? **YES** **NO** **DON'T KNOW**
If yes, briefly describe: _____
_____

Has your child made any suicide attempts? **YES** **NO** **DON'T KNOW**
If yes, briefly describe: _____
_____

Has your child ever been abused or neglected? **YES** **NO** **DON'T KNOW**
If yes, circle those that apply and briefly describe:

(circle all that apply)	Briefly describe
Physical	
Verbal / Emotional	
Sexual	
Neglect	

Is there any history of mental health problems in the child's family?
YES **NO** **DON'T KNOW**
If yes, briefly describe: _____
_____

How do you typically discipline your child? _____

Are there any additional concerns about your child? _____