MindWorks Psychological Services
7450 Dr. Phillips Blvd. Suite 312, Orlando, Fl 32819
310 S. Dillard Street Suite 160 Winter Garden, Fl 34787
Phone 407.415.1450 Fax 321.234.5587
http://www.MindWorksPysch.com

Child Psychology History Form

Child's full name: ______________________________ Date of birth: __________ Gender: M/F

Your name: ______________________ Relationship to child: ____________________________

Address: ____

Email: ___________________________ Phone number: _________________ can I text you? Y/N
(If you prefer to fill this form out line, please call us and we will get this form to you via email)

Reason for Referral:

Is there someone I can thank for referring you? Or how did you find me? __________________________

Briefly state the main concerns for which you are presently seeking help for your child:
____
____

What things have you tried to correct these concerns? ___________________________________
____

Family Information:

Names of child's legal guardians: ____

Relationship to child: ____

Highest grade completed by mother: _________ Highest grade completed by father: ________

Mother's Occupation: __________________ Father's occupation: _________________

Parents' marital status: ☐Married ☐Divorced ☐Separated ☐Deceased ☐Never Married

If separated or divorced, age of child at the time: ________ Dates of any remarriages: ____________

Frequency of visitation with non-custodial parent: ____________________________________

Other people who care for your child a significant amount of time: __________________________

Please list all the members of your child's immediate family (include any half or stepsiblings):

Name	Age	Relationship to child	Living within household
__________________________	_____	__________________	Yes/No
__________________________	_____	__________________	Yes/No
__________________________	_____	__________________	Yes/No

Pregnancy and Development:

Was the pregnancy normal? Yes/No (describe): ____
____

Was there maternal exposure to illicit substances? Yes/No (describe): ____________________________

Length of pregnancy (months) ______ Number of weeks early ______ or late ______

Type of delivery: ☐Vaginal ☐Breech ☐Cesarean ☐Forceps aided

Complications during labor or delivery? Yes/No (describe): ______________________________
____

Birth weight: ______lbs. ______oz. Number of days in the hospital: ______ Apgar scores: _____/_____

Newborn difficulties ☐None ☐Cyanosis (turned blue) ☐Stay in NICU or special care nursery
Other: ____

Indicate age at which your child achieved the following:

Sat without support ______ Spoke first words ______
Crawled ______ Put 2-3 words together ______
Walked ______ Said sentences ______
Toilet trained ______ Dressed self ______

Describe your child's temperament (personality) as an infant (e.g., irritable, happy, easy-going, demanding):
____
As a toddler: ____
As a child: ____

Concerns regarding your child's early development (cognitive, speech and language, gross and fine motor skills): Yes/No (describe): ____

Concerns about feeding as infant: Yes/No (describe): ________________________________
____

Does your child have any problems with toileting? Yes/No (describe): ______________________
____

Does your child have any problems with going to sleep/staying asleep? Yes/No (describe):
____
____

How does this child compare with his/her siblings? ____________________________________
____

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Does your child have a history of emotional or behavioral difficulties, including:
Any history of: If so, approximate age began? Check if still occurring.

Head banging____
Stuttering____
Breath holding____
Day soiling ____
Temper tantrums ____
Nail biting ____
Excessive Jealousy _______________________________________
Hitting____
Hyperactivity____
Difficulty paying attention____________________________________
Daydreams frequently_______________________________________
Frequent crying ____
Irritability____
Excessive thumb sucking ____________________________________
Excessive masturbation _____________________________________
Hurting self ____
Seems to be in own world____________________________________
Obsessive thoughts____
Excessive need to count, touch objects_______________ ____________
Sleep problems ____
Nightmares ____
Bedwetting ____
Excessive fears ____
Excessive fantasizing ______________________________________
Exceptionally sensitive to sounds, tastes, smells or textures (elaborate)_________
____
Intentionally hurting others __________________________________
Problems going to school_____________________________________
Problems making friends_____________________________________
Preoccupation with death____________________________________
Hallucinations or delusions___________________________________
Addictions ____
Threats of suicide or homicide_________________________________

Medical History:

	Circle One	Ages	Describe
Allergies	Yes / No		
Appetite/eating problems	Yes / No		
Asthma	Yes / No		
Clumsiness/poor motor skills	Yes / No		

Chronic constipation	Yes / No		
Chronic ear infections	Yes / No		
Headaches	Yes / No		
Hearing/ear problems	Yes / No		
Head injury	Yes / No		
Nightmares	Yes / No		
Persistent high fevers	Yes / No		
Physical disabilities	Yes / No		
Seizures	Yes / No		
Sleep apnea/snoring	Yes / No		
Surgeries	Yes / No		
Tics/twitching	Yes / No		
Vision/eye problems	Yes / No		
Alcohol use/abuse	Yes / No		
Illicit drug use/abuse	Yes / No		
Risky behaviors	Yes / No		
Vaccination reactions Vaccination status?	Yes/ No		

Please add any additional information about the above concerns: ________________________________

____

Present illnesses for which child is being treated: ____

____

Current Pediatrician's name, address and phone: ____

____

May we contact? Yes/No

Current Medications: Yes/No (if yes, please list):

Name of Medication	Dosage	Name of Prescribing Physician
______________________	__________	___________________________
______________________	__________	___________________________
______________________	__________	___________________________
______________________	__________	___________________________

Difficulties following doctor's advice for medicine or other treatment: Yes/No (describe):
____

Notable childhood diseases other than current illness? (Specify age and any complications): ___________

Hospitalizations: Yes/No (describe): ____

Other issues or concerns regarding your child's health: ___________________________________
____

Family history of medical problems: (describe): ____
____

Family history of attention or learning difficulties: (describe):_________________________________
____
____

Family history of behavioral, emotional or psychological problems, including frequent use of alcohol or other substances to cope with stress: (describe)____
____

Child's handedness: ☐Right ☐Left ☐Both (Ambidextrous)

Please list counselors, psychotherapists, psychologists and psychiatrists who have seen your child:

Age	Provider Name	Service (testing, treatment, medication)	Helpful
____	____________________	________________________________	Yes/No
____	____________________	________________________________	Yes/No
____	____________________	________________________________	Yes/No
____	____________________	________________________________	Yes/No

Psychiatric hospitalizations: Yes/No (describe): ____

History of medications for mood or behavior: Yes/No (describe):___________________________________

School History:

Name of current school: _______________________ _______________________

Grade: ______ Teacher: _________________ Present letter grades: __________________

Skipped grades: Yes/No Which ones? ______ Reason: ________________________
Repeated grades: Yes/No Which ones? ______ Reason: ________________________

Does your child receive any special education, enrichment, or resource services, or attend a gifted and talented program? Yes/No (describe):
____

Favorite subjects?_____________________________ Difficult subjects?______________________________

Has a psychologist ever tested your child? Yes/No When/why? Results and recommendations?
____

If yes, please have a copy of the results mailed to our office, or complete the enclosed release form.

	Circle One	Ages	Describe
Early Education Intervention	Yes/No		
Occupational Therapy	Yes/No		
Physical Therapy	Yes/No		
Speech Therapy	Yes/No		

If your child receives any special education services, please enclose a copy of your child's current Individual Education Plan (IEP) or have it sent by the school.

Teachers report problems in:

Reading	_______________	Attention/concentration	______________
Spelling	_______________	Behavior	______________
Math	_______________	Social skills	______________
Writing	_______________	Emotional adjustment	______________

Has your child ever received detention, been suspended or expelled? Yes/No (describe):
____

Previous schools attended, including pre-school | Dates attended (begin - end)
_______________________________________ | _______________________________________
_______________________________________ | _______________________________________

Briefly describe any problems occurring during your child's attendance at these previous schools:
____
____

Describe any problems your child may have with peers (e.g., bullied, teased, no friends, poor social skills, aggressive, bossy, shy): ____
____

Is your child involved in any clubs, sports, or other organized activities: Yes/No (please list): __________
____

What activities does your child enjoy doing? Friends? ____
____

What method of discipline is most effective for your child? ____

Who is the person your child is most likely to share secrets, worries, and feelings to in the immediate family?____

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Please list some of your child's personal strengths and talents: ___________________________________
____
____

Please check any of the following stressful events that apply to your child or family and describe:

- ☐ Relocations: ____
- ☐ Deaths: ____
- ☐ Illnesses: ____
- ☐ Marital problems: ____
- ☐ Experiencing a traumatic event: ____
- ☐ Physical or sexual abuse or neglect: ____
- ☐ Family and Social Services involvement: _______________________________________
- ☐ Legal issues: ____
- ☐ Other: ____

Please write any additional remarks you may wish to make regarding your child below and how we may be able to help. Thank you for taking the time to complete this information form.

____
____
____
____
____
____

Revised~ 02/2020