Child History Form

Child's Name: ____ Birth Date: ___________________

Today's Date: ________________

Gender: ☐ male ☐ female ☐ Other ___________ Age: _____ Ethnicity/Race: ________________

Legal status of child: ☐ Birth ☐ Adopted (age when adopted: _______) ☐ Stepchild ☐ Foster

If parents are divorced: ☐ Joint legal/physical custody ☐ Sole physical custody ☐ Sole legal custody

Child's address: ____________________________________

____

Home Phone: ___________________________ May I leave a message on voicemail? ☐ Yes ☐ No

Email: _________________________________ May I email you? ☐ Yes ☐ No

I understand that email may not be confidential. _____ please initial

Present concerns/reasons for which you are seeking services? ___________________________________

____

____

____

____

____

____

When did this start to be a concern? ____

Under what conditions do the concerns become worse? _______________________________________

____

____

Under what circumstances do the concerns occur less often/become less severe? _____________________

____

____

Who referred you to this clinic? ____

☐ Physician ☐ Social Worker ☐ Therapist ☐ School Worker

List the child's three greatest strengths:

1. ____
2. ____
3. ____

List the child's three greatest areas for improvement:

1. ____
2. ____
3. ____

Please check any of the concerns that apply or have applied to your child:

( ) Chronic sadness
( ) Difficulty concentrating
( ) Nausea/Vomiting
( ) Agitation
( ) Fearfulness
( ) Fear of loss of control
( ) Intrusive thoughts/memories
( ) Fears others talking about me
( ) Difficulty completing tasks
( ) Difficulty at school
( ) Excessive gambling
( ) Irritability
( ) Memory problems
( ) Withdrawing from others
( ) Reduced interest in activities
( ) Avoidance of social situations
( ) Feeling detached from others
( ) Sexual concerns/difficulties
( ) Alcohol/substance abuse
( ) Problems with school
( ) Staying up for days without sleep
( ) Crying episodes
( ) Loss of appetite
( ) Difficulty making decisions
( ) Restlessness
( ) Trembling/shaking
( ) Nightmares
( ) Easily startled
( ) Difficulty focusing
( ) Tendency to act impulsively
( ) Racing thoughts
( ) Aggressive towards others
( ) Difficulty functioning socially
( ) Thoughts of suicide
( ) Difficulty functioning at work
( ) Fear of leaving home
( ) Pounding heart/palpitations
( ) Self harm behavior
( ) Multiple sexual partners
( ) Problems with peers
( ) Taking on too many tasks
( ) Hear voices others do not hear
( ) Hopelessness
( ) Overeating
( ) Low energy/fatigue
( ) Excessive worry
( ) Flashbacks
( ) Fear of dying
( ) Frequent forgetfulness
( ) Legal Problems
( ) Not well organized
( ) Excessive spending
( ) Self-harming behaviors
( ) Sleep problems
( ) Panic attacks
( ) Shortness of breath
( ) Avoidance of public places
( ) Obsessive thoughts
( ) Frequent headaches
( ) Past physical/sexual abuse
( ) Seeing things others don't see
( ) Recent health issues
( ) Concerns with parenting
( ) Fearful someone is plotting against them
( ) Thoughts of physically hurting others
( ) OTHER___________________________

Friendships:

Does your child have an interest in playing/interacting with other children? ___________________________

____

Does your child have difficulty playing/interacting with other children? _______________________________

____

Temperament:

- ☐ Easy to comfort
- ☐ Quiet
- ☐ Excessive irritability
- ☐ Over-active
- ☐ Other: ____________________

Sensory Concerns:

- ☐ Sensitivity of touch
- ☐ Sensitivity to light
- ☐ Sensitivity to smell
- ☐ Sensitivity to sounds
- ☐ Easily irritated by fabrics/clothing
- ☐ Repetitive motions/actions ________________________

Screen Time:

How many hours per day does your child use electronic devices: _____________________________

What type of media does your child watch: ____

____

Dietary, Sleep and Exercise Habits:

What is your child's current use of caffeine? ____

What time does your child go to bed? ____

How long does it usually take for the child to fall asleep? ____

Does your child wake during the night? ____

At what time does your child wake in the morning? ____

How many hours of sleep does your child typically get at night? ____________________________________

How many days per week does your child engage in at least 30 minutes of exercise? ___________________

Family Background:

Mother's Name: ____ Age __________

Address: ____ ☐ **Address same as child**

____

Home Phone: _______________________

Work Phone: ________________________ May I leave a message on your work voicemail? ☐ Yes ☐ No

Cell Phone: _________________________

Occupation: ________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced (date of divorce: _______________) ☐ Re-Married

Highest Grade Completed: ____________________ Ethnicity/Race: __________________________

History of learning difficulties: ____

History of medical concerns: ____

Father's Name: ____ Age ___________

Address: ____ ☐ **Address same as child**

____

Home Phone: ________________________

Work Phone: ________________________ May I leave a message on your work voicemail? ☐ Yes ☐ No

Cell Phone: _________________________

Occupation: _________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced (date of divorce: ________________) ☐ Re-Married

Highest Grade Completed: _________________ Ethnicity/Race: _________________________

History of learning difficulties: ____

History of medical concerns: ____

Child's Brothers/Sisters:

Age	Gender	First Name	Relationship (sister, brother, step-sister, etc.)

Other individuals living in the child's home:

Age	Gender	First Name	Relationship (step-parent, grandmother, aunt, uncle, etc.)

Infancy and Early Childhood Development:

Child's Physician: ____

Clinic and address: ____

Birth weight: ________________ Birth length: ________________ Gestation: _______weeks

Were there any complications during pregnancy with your child? __________________________________

____

Were any medications or alcohol/drug use during pregnancy? ____________________________________

____

Were there any complications during or shortly after birth? ______________________________________

____

At what age did this child first do the following? (please estimate year/month of age)

____________ Sat alone	____________ Walked alone
____________ Crawled	____________ Spoke first words
____________ Stood alone	____________ Bladder trained during the day
____________ Toilet trained	____________ Bladder trained during the night

Is there any history of bed-wetting after toilet training? ☐ Yes ☐ No If yes, until what age? _______

Does your child wear corrective lenses? ☐ Yes ☐ No

Which hand does this child use for writing or drawing? ☐ Right ☐ Left

Is there any history of the following problems? If yes, please describe.

- ☐ Irritable or hard to manage as infant/toddler ______________________________
- ☐ Walking difficulty ______________________________
- ☐ Unclear speech ______________________________
- ☐ Underweight or overweight problem ______________________________
- ☐ Ear infections (#____) ______________________________
- ☐ Sleep problems ______________________________
- ☐ Fever greater than 105°F______________________________
- ☐ Allergies/asthma ______________________________
- ☐ Eating problems ______________________________
- ☐ Delays in motor skills ______________________________
- ☐ Colic ______________________________
- ☐ Temper tantrums ______________________________
- ☐ Excessive crying ______________________________
- ☐ Head injuries/loss of consciousness ______________________________
- ☐ Seizures ______________________________
- ☐ Hearing problems ______________________________
- ☐ Vision problems ______________________________

Medical History:

Please list any childhood illnesses or surgeries that this child has had and indicate age: ________________
____
____
____

Other medical concerns? ____
____

Is your child currently on medication? Yes No (if yes, please indicate below type and dosage)

Name of medication	Dosage	Date first prescribed	Physician

Has your child received previous mental health services? No Yes (If yes, please describe below)

Type of services and concern	Provider/Facility	Dates of service

Has your child experienced any of the following?

- ☐ Physical abuse ____
- ☐ Sexual abuse ____
- ☐ Verbal/emotional abuse ____
- ☐ Exposure to domestic violence abuse ____

Are there any legal issues that involve your child? ____________________________________
____

Family history of mental health problems (for example, depression, learning difficulties, ADHD, anxiety, alcoholism, mental retardation, schizophrenia, bipolar disorder, etc.): _________________________
____
____
____

Briefly describe the style of parenting used in the household: ____________________________
____
____

Describe how the child is disciplined: ____
____
____

For what reasons is the child disciplined? ____
____
____

Briefly describe the child's friendships: ____
____
____

Child's Education History:

Elementary School: ____

Middle School: ____

High School: ____ Current Grade: ______________

Current Teacher/Preferred School Contact: ____

Has your child been tested for special education services: ☐ Yes ☐ No If yes, when? ________________

Has your child had any behavioral problems at school? ____

Has your child had any difficulty with reading? ____

Has your child had any difficulty with math? ____

Has your child had any difficulty with gross or fine motor skills? ___________________________________