

## Child History Form

Please provide the following information regarding your child. Note: The information you provide here is protected as confidential information.

Please fill out this form completely and bring it to your first session.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial \_\_\_\_\_

Name Your Child Would Like to Be Called (Nickname): \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Name of person completing form: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ May we leave a message?  Yes  No

Cell/Other Phone: (\_\_\_\_\_) \_\_\_\_\_ May we leave a message?  Yes  No

E-mail: \_\_\_\_\_ May we email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact (Nearest relative not living at patient address above):

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you? \_\_\_\_\_

Parent/Legal Guardian Driver's License No. & State: \_\_\_\_\_

### YOUR CHILD'S FAMILY:

Parent's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Health: \_\_\_\_\_ Phone number: \_\_\_\_\_

If deceased, cause of death: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Health: \_\_\_\_\_ Phone number: \_\_\_\_\_

If deceased, cause of death: \_\_\_\_\_

With whom does the child live? \_\_\_\_\_

Sibling Names, Ages, School Attending or Occupation: \_\_\_\_\_

Other parent's address if applicable: \_\_\_\_\_

Please list your child's grade and school attending: \_\_\_\_\_

What is your child's attitude toward school: \_\_\_\_\_

Does your child have an adequate quantity and quality of friendships? Please explain: \_\_\_\_\_

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?  Yes  No

If Yes, previous therapist/practitioner: \_\_\_\_\_

What social agencies are involved in your case? \_\_\_\_\_

Are you or your immediate family currently involved in any legal proceeding(s)? (i.e.: divorce, criminal, civil related issue(s))? \_\_\_\_\_

If yes - name and contact information of attorney: \_\_\_\_\_

What made you seek help at this time? \_\_\_\_\_

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION:**

1. How would you rate your child's current physical health? (please check one)

- Poor       Unsatisfactory       Satisfactory       Good       Very good

Please list any specific health problems your child is currently experiencing:

2. At what age did your child reach these developmental milestones: Turned over \_\_\_\_\_  
Sat alone \_\_\_\_\_ Crawled \_\_\_\_\_ Weaned \_\_\_\_\_ Spoke first words \_\_\_\_\_  
Walked \_\_\_\_\_ Talked in sentences \_\_\_\_\_ Fed self \_\_\_\_\_ Tied own shoes \_\_\_\_\_  
Toilet trained \_\_\_\_\_

3. Has your child ever been prescribed psychiatric medication?  Yes  No

4. Please list all current medications and the physician who prescribed them:

5. Has your child ever been hospitalized?  Yes  No If yes, please provide details:

Date Location Reason Outcome

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6. Pediatrician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

7. Has he/she ever had a head injury?  Yes  No

When and describe: \_\_\_\_\_

8. Has he/she ever lost consciousness?  Yes  No

When and describe: \_\_\_\_\_

9. How would you rate your child's current sleeping habits? (please check one)

Poor  Unsatisfactory  Satisfactory  Good  Very good

Please list any specific sleep problems he/she is currently experiencing (e.g. trouble falling asleep or waking up; snoring; restless sleep; breathing problems; waking up frequently; nightmares; sleepwalking; bedwetting):

10. Please list any difficulties your child is experiencing with his/her appetite or eating patterns:

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11. Is your child currently experiencing overwhelming sadness, grief or depression?  Yes  No

If yes, for approximately how long? \_\_\_\_\_

12. Is your child experiencing anxiety, panic attacks or have any phobias?  Yes  No

If yes, when did your child begin experiencing this? \_\_\_\_\_

13. What significant life changes or stressful events has your child experienced recently?

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**ABUSE/TRAUMA:**

Has your child ever been physically/sexually/emotionally abused?  Yes  No

Alleged abuser(s): \_\_\_\_\_

At what age(s): \_\_\_\_\_ How did this affect your child? \_\_\_\_\_

Has your child ever experienced any other severe trauma?  Yes  No If yes, explain how child was affected: \_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY:**

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

<b>Family History:</b>	<b>Check one:</b>	<b>Family Member Relationship:</b>
Alcohol/Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eating Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Obsessive Compulsive Behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Psychiatric Hospitalizations	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Suicide Attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Has someone in your family ever been arrested?  Yes  No

<u>Name</u>	<u>Relationship to Your Child</u>	<u>What Charges</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Anything else not covered above? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date Completed