



Child and Family History

Date: _____

Referred by: _____

Child's Name: _____ Date of Birth: _____ Age: _____

Social Security #: _____ Gender: Male Female Race: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work #: _____ Cell # _____ E-mail _____

School: _____ Grade: _____ Is child in Special Education? Yes no

Mother's Name: _____ Age: _____ Education: _____

Place/Type of Employment: _____

Father's Name: _____ Age: _____ Education: _____

Place/Type of Employment: _____

Are the parents (circle which) - *Married* *Separated* *Divorced* *Never Married to One Another*

Is there another legal guardian besides the parent(s)? Yes no If yes, please state name, address, phone number, and relationship to child (e.g., foster parent, grandparent, etc.): _____

Is the child adopted? Yes no If yes, age when adopted: _____

Please list all other adults and children living in the home:

<u>Name</u>	<u>Age</u>	<u>Relationship to this child</u>	<u>Medical Educational or Emotional Problems</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name of person completing this form: _____ Relation to child: _____

What is your primary concern regarding your child?

Describe the problem(s) your child is having and when the problem(s) began:

What issues, situations, or other problems have contributed to this difficulty?

What information/help do you hope to gain from this evaluation? What questions would you like answered?

DEVELOPMENTAL and MEDICAL HISTORY

PREGNANCY AND DELIVERY

Length of pregnancy (e.g., full term, 40 weeks, 32 weeks, etc.): _____ Length of delivery (in hours): _____

Mother's age when child was born: _____ Child's birth weight: _____ Was pregnancy planned? Yes No

Please *circle* any of the following that occurred during pregnancy or delivery:

Unusual bleeding Excessive weight gain (more than 30 lbs.) Toxemia/preeclampsia

Rh factor incompatibility Frequent nausea or vomiting Serious illness or injury

Took illegal drugs Used alcoholic beverages (amount _____) Smoked cigarettes

Took prescription drugs (name of medications : _____)

Medication to ease labor pains Forceps used during delivery Induced delivery

Breech delivery Cesarean section Other problems _____

Please *circle* any of the following conditions if they affected your child during delivery or within the first few days after birth:

Injured during delivery Heart or lung distress during delivery Delivered with cord around neck

Needed oxygen Trouble breathing following delivery Was cyanotic, turned blue

Was jaundiced, turned yellow Had an infection Had seizures

Was given medications Born with a congenital defect Was in hospital more than 7 days

Infant Health and Temperament:

Please *circle* any of the following if they describe your child's behavior during his/her first 12 months:

Difficult to feed	Difficult to get to sleep	Colicky
Difficult to put on a schedule	Cheerful	Alert
Affectionate	Sociable	Easy to comfort
Difficult to keep busy	Overactive, in constant motion	Very stubborn, challenging

EARLY DEVELOPMENTAL MILESTONES:

At what age did your child first accomplish the following:

Smiled _____ Sat without help _____ Crawled _____ Stood _____
 Fed self _____ Walked alone _____ Said first word _____ Said phrases _____
 Bowel trained, day and night _____ Bladder trained, day and night _____ Dressed self _____
 How do you feel your child developed? ___ Faster than average ___ Average ___ Slower than average

HEALTH HISTORY

Child's Pediatrician / Family Doctor: _____ Date of last physical exam: _____

At any time has your child had the following:

	<u>Never</u>	<u>Past</u>	<u>Present</u>
Asthma	○	○	○
Allergies	○	○	○
Diabetes, Arthritis or other chronic illnesses	○	○	○
Epilepsy or seizure disorder	○	○	○
Febrile seizures	○	○	○
Chicken pox or other common childhood illness	○	○	○
Heart or blood pressure problems	○	○	○
High fevers (over 103°)	○	○	○
Broken bones	○	○	○
Severe cuts requiring stitches	○	○	○
Head injury with loss of consciousness	○	○	○
Lead poisoning	○	○	○
Surgery	○	○	○
Lengthy hospitalization	○	○	○
Speech or language problems	○	○	○
Chronic ear infections	○	○	○
Hearing difficulties	○	○	○
Eye or vision problems	○	○	○
Fine motor / handwriting problems	○	○	○
Gross motor difficulties, clumsiness	○	○	○
Appetite problems (overeating or under eating)	○	○	○
Sleep problems (falling asleep, staying asleep)	○	○	○
Soiling problems	○	○	○
Wetting problems	○	○	○

Other health difficulties:

Diagnosis	Location	Date of Diagnosis	Diagnosing Physician

What was the date of you child's last vision exam? _____ Results? _____

Has your child ever had tubes in their ears? Yes No. If Yes, Date(s) _____ Age(s) _____

Has your child ever been examined by an audiologist? Yes No If Yes, When? _____ Results? _____

Please list prior surgeries.

Type of Surgery	Date	Physician

Has your child received Chemotherapy? YES NO If YES complete the following.

Dates of Treatment (inclusive)	Number of rounds	Type of chemotherapy	Side effects?

Date of last treatment: _____ Are more scheduled at this time? _____

Has your child received Radiation or Gamma Knife treatments? YES NO If Yes complete the following:

Type of Treatment (i.e. radiation/gamma knife)	Dates of Treatment (inclusive)	Side Effects?

Date of last treatment? _____ Are more scheduled at this time? _____

List both prescription and over-the-counter medications your child is presently using for any physical conditions:

Medicine	Dosage	Reason for taking

Your child's overall general health is ___ Excellent ___ Good ___ Fair ___ Poor

Your child's physical abilities compared to other children his/her age: *(Please Circle)*

Below Average Average Above Average

Has your child ever had physical/occupational therapy? When? Where? How Often?

Your child's speech/language abilities compared to other children his/her age: *(Please circle)*

Below Average Average Above Average

Has your child ever had Speech Therapy? When? Where? How Often?

Have their ever been any concerns about his/her development?



FAMILY

Is there a pattern of physical illness in your family which keeps repeating (e.g., heart disease, cancer, seizures, etc.)? If so, what?

Has your child or any other person in your family/extended family, including your self, experienced any of the following problems?

<u>Concern</u>	<u>Person(s) who experienced this/relationship to patient</u>
Anxiety	_____
Depression	_____
Bipolar Disorder	_____
Epilepsy	_____
Suicide	_____
Stuttering	_____
Explosive Temper	_____
Mental Retardation	_____
Learning Disabilities	_____
ADHD	_____
Schizophrenia	_____
Alcohol abuse	_____
Drug abuse	_____
Emotional Problems	_____
Other: _____	_____

EDUCATION

List all schools your child has attended in order:

<u>Name of school</u>	<u>Location</u>	<u>School District</u>	<u>Grades Attended</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child ever received services through Early Childhood Intervention (ECI) or Pre-School Program for

Children with Disabilities (PPCD)? Yes No If yes, please state what agency they received these services through and the ages during which your child received these services. _____

Does he/she have any learning problems in school? Y N If yes, what are the problems? _____

At what age and grade were these problems first noticed? _____

What actions were taken at that time? _____

Has he/she ever had psychological or educational testing for learning or behavior issues at school? Yes no
If yes, for what issues? _____

When was date of last testing? _____ Results? _____

Is child receiving services under Section 504 or Special Education? Yes No If Yes, please describe all services they are currently receiving and those received in the past _____

Have these services been helpful to your child? Yes No

Has he/she ever repeated or skipped a grade? Yes No If yes, which one(s)? _____

How has his/her attendance been? _____ What types of grades? _____ Have the grades changed a lot? _____

Does he/she have any behavior or discipline problems at school? Yes No If yes, what problems? _____

What types of extracurricular school activities does your child participate in (e.g., clubs, band, drama, etc.)? _____

Is there any family history of learning or school behavior problems in the family? Yes No If yes, what were/are the problems and what is the individual's relationship to patient? _____

SOCIAL HISTORY

What are your child's major strengths? _____

What are your child's major weaknesses? _____

How many close friends does your child have? None 1 2 3 4 or more

Does your child have other friends besides those you would classify as "close" friends? Yes no

What is the age range of his/her friends? _____ Are most of the friends older, younger or same age (circle which)?

How does your child get along with his/her friends? _____

Has there been a change in his/her circle of friends lately? Yes no If yes, what has been the change? _____

Do his/her friends tend to get into trouble? Yes No

What losses, changes, crises, and transitions do you believe have significantly impacted your child's life (e.g., divorce, arrests, graduation, moves, death in family, etc.)? _____

Is there anything else about your child's lifestyle, including the family, that would be helpful for me to know? _____

PSYCHOLOGICAL TREATMENT HISTORY

Has your child ever been in counseling before? Yes no If so, with whom? _____

What was the primary problem for which he/she was in counseling? _____

When was the counseling? _____ For how long? _____ What was the outcome? _____

Has your child ever been hospitalized for emotional problems and/or alcohol/drug treatment? Yes no
If so, when _____, where _____, outcome _____

What medications has your child taken in the past for emotional problems? _____

What medications is your child currently taking for emotional problems? _____

Who is prescribing these medications? _____

Has your child ever completed psychological testing? Yes no If so, with whom? _____
When? _____ What was the diagnosis or recommendations? _____

BEHAVIORAL and EMOTIONAL CONCERNS

Please check any of the following if your child used to exhibit and/or presently exhibits any of these problems:
(Do not check if your child never exhibited the problem. "Now" means within the last 3-6 months)

	<u>Past</u>	<u>Now</u>
Thoughts of hurting self	_____	_____
Thoughts of committing suicide	_____	_____
Plans to commit suicide	_____	_____
Attempts to commit suicide	_____	_____

Threats to commit suicide	_____	_____
Actually harmed someone	_____	_____
Thoughts of harming someone	_____	_____
Plans to harm someone	_____	_____
Attempts to harm someone	_____	_____
Threats to harm someone	_____	_____
Depressed or irritable mood most of the day for at least 2 weeks	_____	_____
Markedly lower interest or enjoyment in almost all activities	_____	_____
Significant weight loss, when not dieting	_____	_____
Significant weight gain	_____	_____
Decreased or increased appetite nearly every day	_____	_____
Insomnia at night or excessive sleep during the day, nearly every day	_____	_____
Agitated or excessive movement nearly every day	_____	_____
Lethargic, sluggish, slow moving nearly every day	_____	_____
Fatigue and loss of energy nearly every day	_____	_____
Feelings of worthlessness or excessive, inappropriate guilt nearly every day	_____	_____
Diminished ability to think or concentrate nearly every day	_____	_____
Recurrent thoughts of death	_____	_____
Recurrent thoughts of suicide	_____	_____
Was very depressed every day for at least two weeks	_____	_____
Was somewhat depressed or irritable more days than not over past 12 months	_____	_____
	Past	Now
Mood was unusually giddy, joyous or ecstatic for at least 1 week	_____	_____
Mood was persistently expansive (felt super-human or able) for at least 1 week	_____	_____
Mood was abnormally and persistently irritable for at least 1 week	_____	_____
<i>During the week or more he/she showed one of the above 3 moods did he/she:</i>		
Have inflated self-esteem or felt grandiose about self	_____	_____
Show decreased need for sleep	_____	_____
Was more talkative than usual and seemed pressured to keep talking	_____	_____
Skip from one idea to another as if his/her ideas were flying rapidly by	_____	_____
State that his/her thoughts seemed to be racing	_____	_____
Become unusually persistent in accomplishing tasks	_____	_____
Seem very agitated, overly active, or abnormally restless	_____	_____
Showed excessive involvement in pleasurable but potentially harmful activities	_____	_____
Excessive anxiety and worry about a number of event or activities	_____	_____
Anxiety on most days for at least 6 months	_____	_____
Restless and feels on edge	_____	_____
Easily fatigued or tired	_____	_____
Difficulty concentrating or mind going blank	_____	_____
Irritability	_____	_____
Muscle tension	_____	_____
Difficulty falling asleep, staying asleep, or restless sleep	_____	_____
Unreasonable fear in social settings where others may notice or scrutinize him/her	_____	_____
Strong fear of being humiliated or embarrassed in front of others	_____	_____
Unreasonable, excessive fear of an object or situation (e.g., animal, heights, etc.)	_____	_____
Recurrent, excessive distress when separated from home or parent	_____	_____
Persistent worry that parent will leave or he/she will lose parent	_____	_____
Nightmares	_____	_____
Repeated complaints of headaches, stomachaches, nausea or vomiting	_____	_____

Repeated concerns about having a physical disorder or disease	_____	_____
Compulsively checks, counts, puts in order, or cleans, often in rigid fashion	_____	_____
Hears voices or sees things that are not really there	_____	_____
Believes that others are trying to harm him	_____	_____
Believes that others are controlling his mind	_____	_____
Is extremely suspicious of others	_____	_____
Others view his behavior and manner of speaking as odd or “crazy”	_____	_____
Often loses temper	_____	_____
Often argues with adults	_____	_____
Often actively defies or refuses adults' requests or rules	_____	_____
Often deliberately annoys people	_____	_____
Often blames other for his/her mistakes or misbehavior	_____	_____
Is often touchy or easily annoyed by others	_____	_____
Is often angry or resentful	_____	_____
Is often spiteful or vindictive	_____	_____
Often bullies, threatens, or intimidates others	_____	_____
Often initiates physical fights	_____	_____
Has used a weapon that can cause serious physical harm (e.g., gun, bat, brick, etc.)	_____	_____
Has been physically cruel to people	_____	_____
Has been physically cruel to animals	_____	_____
Has stolen while confronting a victim (e.g., mugging, purse snatching, etc.)	_____	_____
Has forced someone into sexual activity	_____	_____
	Past	Now
Has deliberately engaged in fire setting with intention of causing damage	_____	_____
Has deliberately destroyed others property (other than by fire setting)	_____	_____
Has broken into someone else's house, building, or car	_____	_____
Often lies or “cons” to obtain goods or favors and avoid obligation	_____	_____
Has stolen items without confronting a victim (e.g., shoplifting, forgery, etc.)	_____	_____
Often stays out at night despite parental prohibitions	_____	_____
Has run away from home, foster care, group home overnight	_____	_____
Is often truant from school	_____	_____
Often fails to give close attention to details or makes careless mistakes	_____	_____
Often has difficulty sustaining attention in tasks or play activities	_____	_____
Often does not seem to listen when spoken to directly	_____	_____
Often does not follow through on instructions and fails to finish work	_____	_____
Often has difficulty organizing tasks and activities	_____	_____
Often avoids, dislikes or is reluctant to engage in tasks requiring sustained effort	_____	_____
Often loses things necessary for tasks or activities (e.g., books, tools, pencils, etc.)	_____	_____
Is easily distracted by extraneous stimuli	_____	_____
Is often forgetful in daily activities	_____	_____
Often fidgets or squirms in seat	_____	_____
Often leaves seat in class or other situations where remaining seated is expected	_____	_____
Often runs or climbs excessively or feel restless and wants to move about	_____	_____
Often has difficulty playing quietly	_____	_____
Often talks excessively	_____	_____
Often blurts out answers before the other person has finished talking	_____	_____
Often interrupts or intrudes on others	_____	_____
Often has difficulty awaiting his/her turn	_____	_____

