

Child History Form

Child's Name: _____ Birth Date: _____

Today's Date: _____

Gender: male female

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: _____

Present concerns/reasons you are seeking services? _____

When did this start to be a concern? _____

Who referred you to this clinic? _____

Physician Social Worker Therapist School Worker

Family Background:

Mother's Name: _____ Age _____

Address: _____ **Address same as child**

Home Phone: _____ Occupation: _____ Work Phone: _____

Marital Status: Married Single Divorced (date of parent's divorce: _____)

Highest Grade Completed: _____ Ethnicity/Race: _____

History of learning difficulties: _____

History of medical concerns: _____

Father's Name: _____ Age _____

Address: _____ **Address same as child**

Home Phone: _____ Occupation: _____ Work Phone: _____

Marital Status: Married Single Divorced (date of parent's divorce: _____)

Highest Grade Completed: _____ Ethnicity/Race: _____

History of learning difficulties: _____

History of medical concerns: _____

Brothers/Sisters:

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

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

Name of medication	Dosage	Date first prescribed	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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? _____

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.): _____

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? _____

Friendships:

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 _____

Dietary, Sleep and Exercise Habits:

What does your child/adolescent eat for breakfast?

Meal Type 1: _____ How many days per week? _____

Meal Type 1: _____ How many days per week? _____

What does your child/adolescent eat for lunch?

Meal Type 1: _____ How many days per week? _____

Meal Type 1: _____ How many days per week? _____

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? _____