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.)

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
_____ Crawled
_____ Stood alone
_____ Toilet trained
_____ Walked alone
_____ Spoke first words
_____ Bladder trained during the day
_____ 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 their 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? _____