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CHILD HISTORY FORM

Date: ___________________
Patient's Name: _______________________________ Age: __________ Date of Birth: ___________
Name of Person Completing this Form: ____
Address: ____
____
Best phone number: ____
Grade: __________________________ School: _______________________________________
Handedness: Right Left Mixed
Ethnicity or Race _______________________ Primary Language _________________________

Who referred you to my office?____

What is your major concern that led you to seek help for your child? ________________________
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____
____
____

What other concerns do you have about your child? ____________________________________
____
____
____

Has your child been diagnosed with any psychiatric conditions? If so, what are they? _________
____
____

Does your child currently have a psychiatrist? Yes _____ No _____
Name: ____________________________________
Do your child currently have a therapist? Yes _____ No _____
Name: ____________________________________

MEDICAL HISTORY

Primary Care Provider ____

For what conditions is your child currently being treated, including those being treated by medical providers other than your primary care provider?

____

____

____

Please list all current medications, dosages and duration of use:

Medication	Dosage	Approximate Duration of Use

Please list all surgeries with approximate dates or ages: __________________________________

____

____

Please list all hospitalizations with approximate dates or ages: ______________________________

____

____

What other medical or physical problems has your child had? Please mark all that apply.

___ Head injury/concussion ___ Respiratory problems ___ Headaches/migraine

___ Gastrointestinal problems ___ Chronic ear infections ___ Hearing/speech disorders

___ Diabetes/Hypoglycemia ___ Seizure(s) ___ Loss of consciousness

___ Thyroid problems ___ Heart problems ___ Arthritis/Joint pain

___ Hypertension ___ Neurological problems (numbness, tingling, weakness)

If you would like to provide further explanation of the items you checked: _______________________

____

____

Has your child ever seen a neurologist for any reason? ____
____
____

Does your child have any allergies? ____
____
____

On average, how many hours of sleep does your child get per night? ___________________________

Please check any of the following sleep problems you have now or have experienced in the past:

___ Difficulty falling asleep

___ Frequent waking

___ Nightmares

___ Sleeping too much

___ Difficulty waking in the morning

___ Not rested after sleep

___ Sleep apnea

___ Teeth grinding

Do your child exercise regularly? No ___ Yes ___

Do you have any concerns about your child's involvement with drugs or alcohol? If so, please describe:
____
____
____

DEVELOPMENTAL HISTORY

Were there any problems/complications during pregnancy or delivery? No ___ Yes ___ Unsure ___
If so, describe: ____

Was your child adopted? No ___ Yes ___ If yes, at what age? _________________________________

Were there any delays in your child's development of language? No ___ Yes ___ Unsure ___
If so, describe: ____

Were there any delays in your child's development of motor skills, such as sitting up independently, crawling and walking? No ___ Yes ___ Unsure ___
If so, describe: ____

To your knowledge, has your child experienced physical, sexual or emotional abuse?
No ___ Yes ___ Unsure ___
If so, describe: ____
____

Has your child experienced any significant stressors, such as serious illness, frequent moving, family drug or alcohol abuse, serious financial stress within the family?
No ___ Yes ___ Unsure ___
If so, describe: ____
____

Please check any of the following that have been a problem for your child:

____ Reading difficulties, including decoding or reading comprehension

____ Math difficulties

____ Writing difficulties, including poor spelling and handwriting

____ Poor visual-spatial skills (drawing, copying figures)

____ Poor grades

____ Behavior problems

____ Peer problems

Has your child ever received special education services, such as an Individualized Education Program (IEP) or a 504 accommodation plan? If so, provide approximate dates of implementation/discontinuation and describe the services received:
____
____
____

FAMILY/SOCIAL ISSUES

Who is living the home? ____
____
____

Do your child have a social support network? ____
____

Has your child ever struggled to establish or maintain friendships? No ___ Yes ___ Unsure ___
Additional explanation (optional):
____
____

What are your child's preferred play activities/how does he or she spend free time?
____
____

What are your child's strengths? ____
____

BEHAVIORAL ISSUES

Please indicate if your child has had difficulty with any of the following areas:

___ Inattention/distractibility
___ Hyperactivity/impulsivity
___ Depression
___ Poor anger management
___ Compulsive behavior
___ Agitation
___ Panic attacks
___ Phobias
___ Muscle/Verbal Tics
___ Obsessive thinking
___ Inability to read social cues
___ Poor self-esteem

If you would like to provide further explanation of the items you checked: __________________________
____
____

Have your child ever been violent or destructive? Has he or she ever hurt an animal or person intentionally, or threatened to harm or kill someone? ____
____

Has your child ever been arrested or had legal problems? ____
____

To your knowledge, has your child ever considered suicide or attempted suicide? If yes, please describe.
____
____

Please list family psychiatric history. Are you aware of any of your biological relatives having been diagnosed with a psychiatric or mental health disorder (such as depression, anxiety, Bipolar Disorder, PTSD, schizophrenia), an attention disorder (such as ADHD), a learning disorder (such as dyslexia, dysgraphia or dyscalculia), or a developmental disorder (such as Autism Spectrum Disorder), a personality disorder (Borderline Personality Disorder, Narcissistic Personality Disorder)? If you strongly suspect someone in your family suffered from a disorder that was diagnosed, please include that here:

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GOALS

If you are seeking evaluation, what questions do you (and your child) have that you would like to have answered through the evaluation process? What are your goals for the evaluation? ________________

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If you are seeking therapy for your child, what your/his or her goals? ___________________________

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