

Please list the child's siblings

<u>Name</u>	<u>Age</u>	<u>Lives with Child</u>	
		Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No

Are there other individuals who also live in the household? If yes, please list.

<u>Name</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Information

Child's School _____ Grade _____

School Address _____

School Phone Number _____

School Contact Person _____

Relationship to Child _____

Legal Information

Does your child or family have any legal involvement? Yes No

If so, please explain.

Mental Health History

What concerns do you have about your child? When did they start?

Please circle any of the following areas of concern, either past or present?

Alcohol/Drug Abuse	Medical Issues	Depressed Mood	Body Image
Homicidal Thoughts	Aggression	Legal Involvement	Physical Complaints
Distractibility	Bedwetting	Problems Finishing Work	Obsessions/Compulsions
Decreased Attention	Soiling	Suicidal Thoughts/Acts	Binge Eating
Poor Concentration	Helplessness	Hallucinations/Delusions	Lying
Sleeping Problems	Shyness	Bullying/Teasing	Fighting
Motor/Vocal Tics	Impulse Control Problems	Confused Often	Stealing
Hyperactivity	Low Self-Esteem	Nightmares	Fire Setting
Oppositional	Food Issues	Family Problems	Trauma
Irritability	Cruelty to Animals	Excessive Worrying	Anger Management
Sexual Abuse	Runaway	Separation Anxiety	School Problems
Physical Abuse/ Neglect	Witnessing Domestic Violence	Self Harming Behavior	Parental Separation/Divorce

How are these issues affecting your child and/or family?

Has your child/family ever received psychological services in the past? If so, where and when?

Were these services helpful to you and your child? Yes No

Are there any psychological/psychiatric problems in the family such as ADHD, Bipolar Disorder, Schizophrenia, Depression or Anxiety?

Relationship to Child

Problem/Diagnosis

Developmental History

Pregnancy and Delivery

Length of Pregnancy: Full Term Premature at _____ weeks Late

Type of delivery _____

Mother's age at child's birth _____ Child's Birth Weight _____

Did any of the following conditions occur during the pregnancy/delivery?
(Please Circle)

Toxemia	Used Alcohol	Frequent Nausea	Serious illness or injury
Took Illegal Drugs	Forceps used during delivery	Smoked cigarettes	Took prescription medications

Infancy

Did any of the following conditions affect your child during delivery/infancy?
(Please Circle)

Born drug positive	Injured during delivery	Heart distress
Cord around neck	Trouble breathing	Needed Oxygen
Congenital Defect	Hospitalized more than 1 week	Required medications
Jaundiced	Seizures	Infections

As an infant, which words best described your child?
(Please Circle)

Difficulty sleeping	Difficulty Feeding	Cranky/unpleasant mood
Affectionate	Cheerful	Active
Difficult to engage	Social	Withdrew from people
Overactive	Tantrums	Difficulty with change

How old was your child when he/she was able to:

Crawl _____

Use words _____

Walk _____

Potty trained _____

Medical History

Child's Physician _____ Phone Number _____

Date of Last Medical Visit? _____

Any Medical Problems? _____

Current Medications:

Medication	Dosage	Reason for Use	Physician
_____	_____	_____	_____
_____	_____	_____	_____

Please circle the appropriate response for your child

Medical Issue	Never	Past	Present
Asthma	Never	Past	Present
Allergies	Never	Past	Present
Chronic Illness (specify_____)	Never	Past	Present
Seizure Disorder	Never	Past	Present
Frequent Headaches/Migraines	Never	Past	Present
Heart Problems	Never	Past	Present
High Fevers	Never	Past	Present
Broken Bones	Never	Past	Present
Stitches	Never	Past	Present
Surgery (specify_____)	Never	Past	Present
Hospitalization	Never	Past	Present
Speech/Language Problems	Never	Past	Present
Motor Problems (clumsy)	Never	Past	Present
Ear Infections	Never	Past	Present
Hearing Problems	Never	Past	Present
Vision Problems	Never	Past	Present
Handwriting Problems	Never	Past	Present
Eating Problems	Never	Past	Present
Diabetes	Never	Past	Present
Stroke	Never	Past	Present
Transplants	Never	Past	Present
Head Injury	Never	Past	Present

Do any of the child's relatives have medical problems?

Relationship to Child

Medical Condition

Please provide any additional information that you would like for us to know:
