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Child History Form

Please provide the following information regarding your child. Note: The information you provide here is protected as confidential information.

Please fill out this form completely and bring it to your first session.

Last Name: ____________________________ First Name: _______________ Middle Initial___

Name Your Child Would Like to Be Called (Nickname): ____

Birth Date: ______ /______ /______ Age: ________ Gender: ☐ Male ☐ Female

Street Address: ____

City ____ State _____________ Zip ____________________

Home Phone: (______) _______________________ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: (______) _______________________ May we leave a message? ☐ Yes ☐ No

E-mail: ____ May we email you? ☐Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact (Nearest relative not living at patient address above):

Name: Address: Relationship: Phone:

____

Who referred you? ____

Patient's SSN: __________________________ Driver's License No. & State __________________________

Parent/Legal Guardian Driver's License No. & State: ____

YOUR CHILD'S FAMILY:

FATHER

Name: ____ Age: _____________________________________

Occupation: ________________________________ Health: ____

If deceased, cause of death: ____

MOTHER
Name: ____ Age: __________________________________

Occupation: ______________________________ Health: _______________________________________

If deceased, cause of death: ____

With whom does the child live? ____

Sibling Names, Ages, School Attending or Occupation ____

____

Other parent's address/phone # if applicable: ____

____

Please list your child's grade and school attending: ____

What is your child's attitude toward school: ____

Does your child have an adequate quantity and quality of friendships? Please explain: ___________________

____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No
If Yes, previous therapist/practitioner: ____

What legal/social agencies are involved in your case? ____

____

What made you seek help at this time? ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your child's current physical health? (please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific health problems your child is currently experiencing:

____

____

2. At what age did your child reach these developmental milestones: Turned over _______________
Sat alone __________ Crawled __________ Weaned __________ Spoke first words ______________
Walked __________ Talked in sentences _________ Fed self __________ Tied own shoes _________
Toilet trained _________

3. Has your child ever been prescribed psychiatric medication? ☐ Yes ☐ No

4. Please list all current medications and the physician who prescribed them:

____
____

____

5. Has your child ever been hospitalized? ☐ Yes ☐ No If yes, please provide details:

Date Location Reason Outcome

____

____

____

6. Pediatrician's Name: ______________________________ Phone Number: __________________________

7. Has he/she ever had a head injury? ☐ Yes ☐ No

When and describe: ____

8. Has he/she ever lost consciousness? ☐ Yes ☐ No

When and describe: ____

9. How would you rate your child's current sleeping habits? (please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems he/she is currently experiencing (e.g. trouble falling asleep or waking up; snoring; restless sleep; breathing problems; waking up frequently; nightmares; sleepwalking; bedwetting):

____

10. Please list any difficulties your child is experiencing with his/her appetite or eating patterns:

____

11. Is your child currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No

If yes, for approximately how long? ____

12. Is your child experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No

If yes, when did your child begin experiencing this? ____

13. What significant life changes or stressful events has your child experienced recently?

____

____

____

ABUSE/TRAUMA:

Has your child ever been physically/sexually/emotionally abused (please circle)? ☐ Yes ☐ No

Alleged abuser(s): ____

At what age(s): ___________ How did this affect your child?____

Has your child ever experienced any other severe trauma? ☐ Yes ☐ No

If yes, explain, and how child was affected: ____

____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

Family History:	Check one:	Family Member Relationship:
Alcohol/Substance Abuse	☐ Yes ☐ No	______________________
Anxiety	☐ Yes ☐ No	______________________
Depression	☐ Yes ☐ No	______________________
Domestic Violence	☐ Yes ☐ No	______________________
Eating Disorders	☐ Yes ☐ No	______________________
Obsessive Compulsive Behavior	☐ Yes ☐ No	______________________
Psychiatric Hospitalizations	☐ Yes ☐ No	______________________
Schizophrenia	☐ Yes ☐ No	______________________
Suicide Attempts	☐ Yes ☐ No	______________________

Has someone in your family ever been arrested? ☐ Yes ☐ No

Name	Relationship to Your Child	What Charges	Outcome

Anything else not covered above?____

____

____

_______________________________ _______________________

Parent/Legal Guardian Signature Date Completed