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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? _____