Name of Child:_____ Age:_____
Date of Birth:_____ Person filling out form:_____
Today's Date:_____ Gender:___ School:_____
Grade:_____ Child's Parents:_____

**Child History**

**I. Why are you seeking help at this time?**

**II. History of Present Areas of Difficulty:**

A. What types of behaviors do you see? How often? What solutions have been tried? How is this behavior a problem? Do other people have concerns about this child?

B. What do you see as the cause of these behaviors? (School/home environment, loss of relationship, traumatic events, sexual/physical abuse)

## III. Developmental History

A. Neonatal:

Prenatal care: Y/N Birth weight: _____ Term: Mos._____

Did mother use alcohol, cigarettes, drugs? Specify:_____

Illness, accidents, stress during pregnancy:_____

Type of delivery_____ Duration of Labor_____

Complications:_____

B. Infancy (0-3):

Age walked:_____ Age talked:_____ Age toilet trained:_____

Any stresses or difficulties:_____

C. Early Years (4-6):

Any difficulty with separation or sexual behaviors:_____

Any stresses or difficulties:_____

D. Elementary Years (6-11):

Any difficulty with school adjustment:_____

Any difficulty with peer relationships:_____

Any stresses or difficulties:_____

## IV. School History:

A. Special Education:_____ Special Classes_____

Grade retention: _____

B. List schools child has attended and corresponding years/grades:

Preschool:_____

Kindergarten:_____

Elementary School(s):_____

_____

Middle School(s):_____

_____

High School(s):_____

_____

C. Give brief history of school experience (academic performance, school changes, attitude, behavior, attendance, suspension)

**V. Family History and Current Living Situation:**

A. Family Composition: please circle: biological, adoptive, foster, other

Marital status:_____

Siblings (genders, ages, biological/step/half/foster):_____

_____

_____

Family Ethnicity/Culture/Religion:_____

_____

B. Clinical Family History: any important medical, psychiatric, or legal family history?

C. History of Family Relationships: please comment on family relationships with siblings, parents (positive, conflictual, avoidant, violence)

D. Family strengths:

## VI. Prior Medical History:

Child's Physician:_____ Phone #:_____

Last Exam:_____ Illnesses:_____

Hospitalizations/Surgeries:_____

Medications:_____

Accidents/Head Injuries:_____

Please describe your child's physical health. Include diet (eating habits, consumption of water, soda pop, coffee, tea), exercise patterns, and stress (what causes stress for child and how he/she copes):

**VII. Prior Mental Health History:**

A. Previous Problems:_____

B. Previous Interventions (Where, when, type, duration):_____

_____

C. Previous Medication:_____

D. Response to Treatment:_____

E. Other Information Regarding Previous Treatment:

**VIII. Activities:**

Describe how your child uses his/her free-time (include amount of time watching TV, playing video/computer games, outside, and peer interaction outside of school):

**IX. Any Other Areas of Concern:**

*Thank you for taking the time to fill out this questionnaire.*