CHILDREN'S HISTORY FORM

NAME:_____
Last First Middle Initial
DOB:_____/_____/_____ AGE:_____ DATE SEEN:_____

INFORMANT:_____ Relationship To Child:_____
Who has legal guardianship of this child?_____
Do all legal guardians request this evaluation?_____
WHAT MADE YOU SEEK HELP AT THIS TIME?_____
_____

PROVIDE BRIEF DESCRIPTION OF MAJOR PROBLEMATIC BEHAVIOR
(including duration and how you have handled it)_____
_____
_____
_____
_____
_____

HAS THE PATIENT HAD ANY PREVIOUS PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS /TREATMENTS? (PLEASE ELABORATE)

Date	**Treating Professional**	**Reason**	**Outcome/Medication:**

_____
_____
_____

SIGNS AND SYMPTOMS Has your child had any of the following**?**
(Please explain items checked in space provide)
Eating problems (poor appetite/picky eater/overeats)_____
Sleeping problems(insomnia, nightmares, sleepwalking, night terrors)_____
Sadness_____ Irritability _____ Temper Tantrums _____
Headaches _____ Stomachaches_____
Other physical complaints not readily explained_____
Hyperactivity _____ Poor Concentration _____ Drugs/Alcohol Abuse_____
Lying_____ Stealing_____ Setting Fires_____ Tics/Unusual Movements_____
Suicidal Thoughts_____ Anxiety/ Fears _____ What? _____
Other Repetitive Behaviors (rituals, mannerism, habits), or Problems/ Concern:
_____
ANY OTHER AREAS OF CONCERNS:_____
_____
_____

ABUSE/ TRAUMA: Has child ever been physically/sexually abused? YES☐ No ☐
GIVE DETAILS:_____
_____
_____
_____

PATIENT'S BIOLOGICAL FAMILY MEDICAL AND PSYCHIATRIC HISTORY: (Fill in details of diagnosis, how related, etc.)

	Maternal Relatives	Paternal Relatives
Alcoholism	_____	_____
Drug Abuse	_____	_____
Mental Illness (type)	_____	_____
Psychiatric Hospitalizations	_____	_____
Mental Retardation	_____	_____
Learning Disabilities	_____	_____
Hyperactivity	_____	_____
Suicide Attempt	_____	_____
Other Medical Illnesses (specify)	_____	_____

PATIENT'S MEDICAL HISTORY (PROBLEMS WHILE MOTHER WAS PREGNANT WITH PATIENT):
Illnesses/Complications:_____
Medications taken:_____
Tobacco/Alcohol/Other Drugs (prescription or otherwise):_____
Length of Gestation (months):_____
Delivery (type: e.g., head first, breech): _____
Birth Weight:_____ Apgar rating:_____
Problems during delivery/shortly thereafter: _____
Medications/Anesthesia during delivery: _____
Length of stay in hospital:_____

CURRENT MEDICATIONS AND DOSES:
_____
_____
_____

SERIOUS INJURIES/ ILLNESSES/ SURGERY IN PAST (high fever, seizures, head injury, etc.)_____
_____

Allergies (specify):_____

CURRENT PHYSICIANS (name, address, date of most recent physical

exam/lab work):_____

DEVELOPMENTAL MILESTONES (in months):
First Word_____ Sat alone_____ Walked _____ Talked in sentences_____
Weaned _____ Fed Self_____ Tied own shoes_____
Toilet training (ease or difficulty: any wetting or soiling afterward)_____

FAMILY HISTORY: Child lives with: mother_____
father_____ adoptive parents_____ other (specify)_____

	NAME	AGE	EDUCATION	OCCUPATION
MOTHER:				
FATHER:				
SIBLINGS:				
STEPPARENT:				

MARITAL HISTORY:

	MOTHER	FATHER
Number of Marriages	_____	_____
Children from previous marriages	_____	_____
Date of most recent marriages	_____	_____
Date(s) of separation(s)	_____	_____

If divorced:
How Long:_____
Custody arrangement:_____
Visitation schedule:_____
Child's adjustment to divorce:_____

Current School_____
Phone:_____ **Teacher:**_____
Special Classes/ SLD/Tract:_____ **Grade:**_____

Signature of person completing form **Date**