

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)

<u>Date</u>	<u>Treating Professional</u>	<u>Reason</u>	<u>Outcome/Medication:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.)

	<u>Maternal Relatives</u>	<u>Paternal Relatives</u>
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:

	<u>MOTHER</u>	<u>FATHER</u>
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** _____