

Please list below the names of the child's siblings:

Sibling Name	Date of Birth	Gender	Ethnicity	Living at Home? (Yes or No)	Grade in School	Relationship to Child (full, step, or half)
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Please list below other members in the household (e.g. friends, roommates, or other relatives):

Name	Date of Birth	Gender	Ethnicity	How Long in home?	Relationship To Child
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Developmental Information

I. PREGNANCY:

Was child adopted? Yes No If yes, at what age?_____

Did mother experience any of the following?

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol/Drug Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Serious Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		

List any medications used during pregnancy:_____

Length of pregnancy:_____

Name of Child: _____ Date of Birth: _____

II. LABOR & DELIVERY:

Were there any problems during labor and/or delivery? Yes No

Were any medications used during labor and/or delivery? Yes No

If yes to either question, please describe: _____

Child's weight at birth: _____ Did child have any problems at birth? Yes No

If yes, please describe: _____

III. EARLY DEVELOPMENT:

At what age did the child do the following things?

Smile _____ Say first words _____ Sit without help _____

Speak in sentences _____ Crawl _____ Completely weaned _____

Walk without support _____ Potty trained _____

Child's first language: _____

If not English, age at which child learned English: _____

Check any problems child had during the first year:

Feeding Sleeping Breathing Colic

Bowel or urinary Inability to be Emotional

habits consoled responsiveness

Describe any other significant problems, injuries, hospitalizations, or major illnesses during this period:

IV. EDUCATIONAL HISTORY:

School/Daycare presently attending: _____ Grade: _____

School address: _____ Phone: _____

School district: _____ Teacher's name: _____

Has your child ever repeated a grade? Yes No If yes, which one(s)? _____

Is your child in special education? Yes No If yes, identifying condition: _____

Is your child in gifted/talented programs? Yes No

Is your child in any other special program? Yes No If yes, describe: _____

Number of elementary schools Number of middle schools/junior Number of high schools
attended _____ high schools attended _____ attended _____

Name of Child: _____ Date of Birth: _____

What does your child like the most and the least about school or daycare/babysitter?

Academic issues (grades, test taking, homework habits)

Behaviors (what you hear in parent/teacher conferences or regularly from caregivers)

Relationships with teachers, authority figures, peers

V. HEALTH HISTORY:

Does your child have a history of any of the following? Check yes or no for each condition

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies (other than drugs) | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia or blood problems | <input type="checkbox"/> | <input type="checkbox"/> | Heart problems or murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | HIV or AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth defects | <input type="checkbox"/> | <input type="checkbox"/> | Hypothyroid or hyperthyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Inherited disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer/tumor | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease or stone |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken pox | <input type="checkbox"/> | <input type="checkbox"/> | Lung disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression or suicide attempts | <input type="checkbox"/> | <input type="checkbox"/> | Measles/German measles |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug/alcohol use | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease (STD) |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear infections | <input type="checkbox"/> | <input type="checkbox"/> | Sickle cell anemia or trait |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder, bulimia, or anorexia | <input type="checkbox"/> | <input type="checkbox"/> | Strep throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema or psoriasis | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB) |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy/seizures | <input type="checkbox"/> | <input type="checkbox"/> | Vision problems (not corrected by glasses) |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Whooping cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Head injury | <input type="checkbox"/> | <input type="checkbox"/> | Other |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain*--currently experiencing? | <input type="checkbox"/> | <input type="checkbox"/> | Pain—regular or recurrent? |
| Yes | No | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Nutrition*--Do you feel your child eats on a daily basis the right amount and a variety of foods for his/her age and height? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Nutrition*--Has your physician ever expressed concerns about your child's eating habits or meeting his/her daily requirements? | | | |

Yes No (Boxed question to be filled in by therapist.)
 If pain and/or nutrition problems checked, therapist discussed referring child to a medical doctor for further evaluation. _____
 (therapist sign and date)

Name of Child: _____ Date of Birth: _____

Female adolescent children:

Number of pregnancies: _____ Live births: _____ Birth control method: _____

For all children:

Has your child ever had a psychological/psychiatric evaluation? Yes No

If yes, when and by whom? _____

Has your child ever been hospitalized for emotional or behavioral reasons? Yes No

If yes, when, where, and how long? _____

VI. MEDICATIONS:

Has your child ever been prescribed medication for emotional or behavioral problems? Yes No

If yes, list in the table below

Check here if currently taking	Name of Medication	Dates prescribed	Dosage	Reason child was taking medication	Physician who prescribed medication	Effectiveness/Side Effects

Is your child currently on any other medications for any reason? Yes No

If yes, please list

Name of Medication	Dates prescribed	Dosage	Reason child was taking medication	Physician who prescribed medication

Allergies to Medication

Does your child have any known medication allergies? Yes No

If yes, list here

Name of Medication	Reaction

VII. ALTERNATIVE MEDICATIONS/INTERVENTIONS:

Check any other health interventions or treatments your child has received

- Herbal remedies
- Homeopathic remedies
- Supplements
- Chinese medicine
- Accupuncture/accupressure
- Traditional healing practices
- Biofeedback
- Chiropractic
- Other (describe):

Any other important health information: _____

Date of child's last physical exam: _____ Are immunizations current? Yes No

Name of your child's physician: _____

VIII. YOUR CHILD:

A. Interests, Activities, and Abilities/Skills: (What does he/she enjoy? What comes easily for your child?)

B. Personality: (Describe your child to me.)

C. What do you like about your child?

D. How do you have fun with your child?

Name of Child: _____ Date of Birth: _____

IX. RELATIONSHIPS:

Who is important to your child? (*Who is your child closest to, talk to, or go to with a problem?*)

A. FAMILY: (Parents, siblings, extended family)

B. FRIENDS:

C. OTHERS:

X. STRESSORS:

Below is a list of stressors that your child may have experienced. Please check all that apply and describe the stressors endorsed.

Stressor checklist: (Check off and describe above all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Death | <input type="checkbox"/> Arrest/Incarceration |
| <input type="checkbox"/> Separation/Divorce | <input type="checkbox"/> Crime victim |
| <input type="checkbox"/> Marital Conflict | <input type="checkbox"/> Mental Health Problem |
| <input type="checkbox"/> Parenting | <input type="checkbox"/> Exposed to violence |
| <input type="checkbox"/> Moves (home, school) | <input type="checkbox"/> Victim of abuse/neglect |
| <input type="checkbox"/> Financial | <input type="checkbox"/> Perpetrator of abuse |
| <input type="checkbox"/> Illness | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Other Trauma | <input type="checkbox"/> Other Stressor |
| <input type="checkbox"/> Change of Primary Caregiver | <input type="checkbox"/> Out of Home Placement |

XI. SOLUTIONS:

What solutions are you hoping for by coming here?

XII. COPING/SUPPORT NETWORKS:

How have you coped with the problems thus far? What have you tried that has helped, even a little?

To whom or what do you turn for support? (Mention any and all of these categories)

- Cultural
- Religious/Spiritual
- Social/Familial (** Who of your family/friends can you count on to help you out? In what ways are they supportive?*)
- Physical (exercise, nutrition, meditation)
- Other
