Child and Family History Form

***If you need more space to answer any of the questions on this form, please indicate next to that question and use the reverse page.**

<u>1. General Information</u>

Child's Name ____________________________________ Date of Birth _____/ _____/_____

Date of Evaluation _____ / _____ / _____ Age _______ Grade (if in school) _____________

Person(s) completing this form and the relationship to the child: _________________________________

____

Who suggested this evaluation? ____

Has your child had a previous psychological evaluation, counseling or psychotherapy?

Yes ☐ No ☐

If yes, please list therapist/evaluators and approximate dates seen: ________________________________

____

Please list your child's strengths, interests and hobbies: ____

____

____

What are you hoping to gain from this evaluation? ____

____

____

Name and phone # of your child's pediatrician: ____

____

Name and phone # of your child's teacher and/or school counselor: _______________________________

____

Name and phone # of other important professional contacts in your child's life: _____________________

____

____

____

2. Your Child's Family History

List all people currently living in child's household(s) and their relationship to the child.

(If child lives in two homes, list both and specify the amount of time in each home):

____

____

____

List others who are not living in the home but who are actively involved with your child:

____

____

Parent(s) current relationship status: ____

Married ☐ Never Married ☐ Separated ☐ Divorced ☐

Remarried ☐ Widowed ☐ Other (specify) ☐ ____

If divorced or separated, what is your custody agreement?

Joint Legal, Joint Physical ☐ Sole Legal, Sole Physical ☐

Joint Legal, Sole Physical ☐ Other (specify) ☐ ____

Child's age at time of separation ______ Child's age at time of divorce _____

If divorced or separated, are both parents consenting to this evaluation/treatment?

Yes ☐ No ☐

If no, please explain ____

____

Are there any concerns or events that have occurred within the family that may be important to know about when working with your child? ____

____

____

What has been helpful and/or not helpful to your family in dealing with these concerns? _______________

____

____

Have there been any community resources that have been useful to your family? ____________________

____

____

3. Child's Developmental History

We appreciate the diversity and complexity of families today. Please complete the following as best describes your family's history and experience.

This is my: Adopted child ☐ Biological child ☐ Foster child ☐

Stepchild ☐ Other ☐ (specify) ____________________

3a. If your child was adopted or was a foster child, please complete this section. If not, please skip to section **3b**.

Age of child when s/he joined adoptive or foster family ____

Child's Birth Place: ____

If adopted, was this adoption: International ☐ or Domestic ☐

If available, knowledge of pre-adoptive or pre-foster placement: ___________________________________

____

____

____

Is there any medical/psychological information about child's birth parents that would be helpful to know?

____

____

____

Age of adoptive or foster parent(s) when child joined adoptive or foster family: ______________________

____

Does the child currently have contact with his/her birth parent(s)?

Yes ☐ No ☐

If yes, what is the contact agreement? ____

____

What is your child's understanding of her/his adoption or foster placement? _________________________

____

____

____

3b. Prenatal History *(Adoptive and foster parents, please complete if you have access to this information)*

Age of Parent(s) at time of birth of this child: ____

____

Number of Prior Pregnancies: _____________ Number of Miscarriages: _________

Were there any medical problems with this pregnancy? _______________________________________

____

Did the mother have any problems with labor and/or delivery? _________________________________

____

Length of pregnancy: ______ weeks

Were there any of the following medical problems?

Toxemia ☐ Diabetes ☐ Bleeding ☐ High Blood Pressure ☐ Other ☐ (specify)______________

During pregnancy, did mother take any medications and/or substances?

Yes ☐ No ☐

If yes, please list all medication and/or substances? ____

____

3c. Early Childhood History:

Child's Health at Time of Birth:

Weight	_____	Apgar score (if known)	_____
Trouble breathing	_____	Jaundiced (got yellow)	_____
Seizures	_____	Cyanotic (turned blue)	_____
Was very jittery	_____	Fever	_____

How old was your child when she/he:

Sat up without help	_____	Walked without help	_____
Spoke first word	_____	Spoke 2-3 word sentence	_____
Bladder trained	_____	Bowel trained	_____

Child's hand preference: Left ☐ Right ☐ Both ☐

Please describe any other difficulties that your child may have had as a newborn or during early childhood?

____

____

Did your child have any of the following difficulties? Yes ☐ No ☐

If YES, please check the appropriate box to indicate age.

	0-3 Mos.	3-12 Mos.	1-3 Yrs.	3-6 Yrs.	6+ Yrs.	Currently
Difficult to comfort						
Colic						
Problems feeding						
Poor appetite						
Trouble falling asleep						
Trouble staying asleep						
Excessive activity level						
Temper tantrums						
Fears/Worries						
Odd or unusual interests						

Please briefly describe any difficulties noted above: ____

____

Does anyone in your child's family have the following difficulties? Yes ☐ No ☐

If YES, please check and list **WHO** they are (e.g., mother, father, sister, paternal grandmother, maternal uncle and note with a "B" if this person is biologically related to the child).

WHO	Parent ______	Parent _______	Sibling	Grandparent	Aunt/Uncle	Other
Trouble with school						
Behavior problems						
Repeated grade						
Mental Retardation						
Depression						
Anxiety						
Suicidal behavior						
Hyperactivity/attention problems						
Drug/Alcohol Problems						
Schizophrenia						
Bipolar (manic depressive) disorder						
Tics or Twitching						

3d. Your Child's Current Health:

Please indicate if your child has any of the following (*please explain all "Yes" answers*)

Allergies? Yes ☐ No ☐

If yes, please list everything that your child is allergic to: ______________________________

____

Allergies to medication? Yes ☐ No ☐

If yes, please list all of the medications that your child is allergic to: ______________________________

____

Asthma? Yes ☐ No ☐ ______________________________

Stomachaches? Yes ☐ No ☐ ______________________________

Lead Poising? Yes ☐ No ☐ ______________________________

Head Injuries? Yes ☐ No ☐ ______________________________

Headaches? Yes ☐ No ☐ ______________________________

Seizures? Yes ☐ No ☐ ______________________________

Ear Infections? Yes ☐ No ☐ ______________________________

Vision Problems? Yes ☐ No ☐ ______________________________

Sleep disturbance? Yes ☐ No ☐ ______________________________

Does your child snore? Yes ☐ No ☐ ______________________________

Please describe your child's sleep habits: ______________________________

____

Any Other Health Concerns? ______________________________

____

____

Is your child currently on medication? Yes ☐ No ☐

If yes, Please list type and dosage(s): ______________________________

____

____

Please list any hospitalizations (medical and psychiatric). Indicate dates. ______________________________

____

____

____

3e. Your Child's School's History

Did your child attend nursery school/daycare? Yes ☐ No ☐ *If yes*, age started: ___________________

Please list any concerns at that time: ____

____

Were there any concerns at kindergarten screening? Yes ☐ No ☐

____

____

Please list all schools your child has attended and at what age and grade ______________________________

____

If your child has a favorite subject, what is it? ____

If there is a particular subject(s) that your child dislikes or has difficulty with please list: _______________

____

Has your child ever experienced any of the following difficulties in school?

learning challenges ☐ social difficulties ☐ behavioral difficulties ☐ emotional difficulties ☐

If yes, when were these difficulties first noticed? Please describe: ___________________________________

____

If yes, has your child been evaluated at school for any of these difficulties? ___________________________

____

Has your child received special help in the past? Yes ☐ No ☐

Is your child currently receiving special help? Yes ☐ No ☐

If yes to either question, please describe the type received of help and who provided it:

____

____

How does your child currently feel about going to school?

Extremely Unhappy 1 __ 2__ 3__ 4__ 5__ Extremely Happy

Does your child receive homework assignments? If so please note completion rate:

Almost Never 1__ 2__ 3__ 4__ 5__ Always

How difficult does your child find schoolwork?

Very Difficult 1__2 __ 3__ 4__ 5__ Easy

Describe your child's relationship with his or her current classroom teacher(s).

Negative 1__ 2 __ 3__ 4__ 5__ Positive

Please describe how your child spends time after school: ____

____

3f. Your Child's Social History

Has your child experienced any major losses and/or separations? Yes ☐ No ☐

If yes, please provide details: ____

____

In the past, has your child had difficulties separating from familiar people?

Yes ☐ No ☐

Is this still a problem? Yes ☐ No ☐

If yes to either, please describe: ____

____

Does your child seek out friends? Yes ☐ No ☐

Do peers seek out your child? Yes ☐ No ☐

Does your child play primarily with children his/her own age? Yes ☐ No ☐

Does your child fight frequently with peers? Yes ☐ No ☐

Do you have any concerns about your child's friendships? Yes ☐ No ☐

If yes, please explain? ____

____

What are three strengths that best describe your child? _____________________________________

____

How does your child spend his or her free time? ____

____

What activities does your child enjoying doing the most? ___________________________________

____

For parents of preteens and teens:

Does your child have a curfew? Yes ☐ No ☐ NA ☐

Does your child adhere to curfew? Yes ☐ No ☐ NA ☐

Does your child date? Yes ☐ No ☐ NA ☐

What is your teen's exposure and/or attitude towards drugs, nicotine, alcohol? ____________________

____

____

Is it of concern to you? ____

____

3g. Your Child's Temperament

Please circle the number that that best corresponds to your child's temperament for each category:

ACTIVITY LEVEL	highly active, always seems to be "on the go"	**1 2 3 4 5 6 7**	calm and content, inactive most of the time
ADAPTABILITY	adapts easily to change	**1 2 3 4 5 6 7**	does not adapt easily to change
REGULARITY	eating, sleeping, and bathroom habits are regular	**1 2 3 4 5 6 7**	eating, sleeping, and bathroom habits are irregular
SENSORY THRESHOLDS	bothered by external stimuli such as loud noises, bright lights, or food textures	**1 2 3 4 5 6 7**	tends to ignore external stimuli such as loud noises, bright lights, or food textures
DISTRACTIBILITY	easily distracted, unable to ignore distractions	**1 2 3 4 5 6 7**	highly focused, not easily distracted
MOOD	overall positive mood, usually pleasant and happy	**1 2 3 4 5 6 7**	overall negative mood, often angry, cries often
PERSISTENCE	sticks with projects until they are done, doesn't give up	**1 2 3 4 5 6 7**	does not stick with projects until they are done, gives up easily
INTENSITY	emotional reactions are intense, even exaggerated	**1 2 3 4 5 6 7**	emotional reactions are mild, low-key
APPROACH/ WITHDRAWAL	willing to try new things, comfortable in social situations	**1 2 3 4 5 6 7**	unwilling to try new things, withdraws in social situations

Comments on your child's temperament: ____
____
____
____
____

3h. Your Child's Cultural/Ethnic/Religious History

The information below may help us understand important influences in your child's life. Please answer the questions below to the extent that you feel comfortable doing so.

What is important for your provider to know about your family's ethnic/cultural background?

____

____

____

____

How would your child describe his or her ethnic/cultural identity? ________________________________

____

____

What language (or languages) is spoken at home? ____

What language is your child most comfortable speaking? ____

What (if any) is your child's religious upbringing and current practice? ______________________________

____

Have your child and/or family experienced stress related to ethnicity and/or cultural/religious practice?

____

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____

____

Please feel free to include any information that has not been directly requested that you feel may be relevant to a biographical history of your child: ____

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