CENTER FOR PSYCHOLOGY AND COUNSELING
118 E. Sunbridge Dr.
Fayetteville, AR 72703
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PATIENT HISTORY – CHILD FORM

Please complete this form to the best of your ability about the patient's childhood history.

Patient's Name: _____ Birth Date: _____ Age: _____ Sex: _____

Who referred the patient to this clinic? _____

FAMILY INFORMATION:

Father's name: _____ Birth Date: _____
Occupation: _____ Employer: _____
Highest School Grade Completed: _____ Other training: _____
Religion: _____

Mother's Name: _____ Birth Date: _____
Occupation: _____ Employer: _____
Highest School Grade Completed: _____ Other training: _____
Religion: _____

Marital Status of parents: _____ Marriage Date: _____
Date divorced, if applicable: _____ Death of parent, if applicable: _____

If parents are divorced, who is the custodial parent? _____

Who does the patient live with: Biological parent ☐ Adoptive Parent ☐ Foster parent ☐
Other: _____

How long has the family lived at the current address? _____

Where else has the family lived during the patient's life? _____

List all persons living in the home:

NAME	AGE	RELATIONSHIP TO PATIENT

PRESENTING CONCERNS:

What do you think is your child's main problem? How long has this been a problem?

What do you believe caused your child's problem?

What have you been told by doctors, teachers and / or others about your child's problem?

Do you have concerns about other family members? ☐ Y ☐ N (if yes, please explain)

What do you expect or hope to have happen as a result of an evaluation?

Persons with developmental problems often act younger than they are. What age level do you think best describes the current behavior of your child?

PATIENT'S HISTORY:

Was the pregnancy planned? ☐ Y ☐ N Medical care began in the _____month of pregnancy

☐ Routine ☐ Sporadic Birth was: ☐ Normal ☐ Caesarean ☐ Breech ☐ Twins or more

Birth weight: Were there any complications? ☐ Y ☐ N (if yes, please explain)

What were your first impressions of your baby? _____

How long did your child stay in the hospital after birth? _____

How many **hours of sleep** does the patient get per night? _____

Complete the following table for all of the mother's pregnancies in chronological order including any miscarriages or stillbirths. (Write on the back if additional space is needed.)

Name	DOB	Birth Weight	Length of Pregnancy	Length of Labor	Problems of birth	Any physical, emotional, behavioral, or education problems?

Has the mother or father of the patient had any serious illness in the past? ☐ Y ☐ N (if yes, please explain)

What stressors have impacted your family recently? (i.e., deaths, marital conflicts, financial worries, etc.)

Please note below if any of the patient's relatives have had any of the following conditions. (For example: brother, parent, grandparent, aunt, cousin)

	Relationship to patient
School Difficulties	_____
Over activity, Attention problems	_____
Mental Illness	_____
Speech Problems	_____
Emotional Problems	_____

CHILDHOOD GROWTH AND DEVELOPMENT:

Motor Skills: Did your child have any motor delay? ☐ Y ☐ N (if yes, please explain)

_____

Language and Hearing: Did your child have any language/hearing delay? ☐ Y ☐ N (if yes, please explain)

_____

Feeding: Did your child have any problems with feeding? ☐ Y ☐ N (if yes, please explain)

_____

Personal: At what age was your child bladder trained? _____ Bowel trained? _____

Social: Do you have any concerns about your child's social development? ☐ Y ☐ N (if yes, please explain)

_____

MEDICAL HISTORY:

Has your child ever been hospitalized? ☐Y ☐N If yes, why_____

Is your child **CURRENTLY** taking any medications? ☐ YES ☐NO

Please list any medications and dosages that your child currently takes:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Does your child have any **allergies to medications**? If so please list

_____

Has your child ever had a serious illness or accident? ☐Y ☐N (if yes, please explain)

Does your child have a history of any of the following:

Heart disease ☐	Headaches ☐	Seizures ☐
Glaucoma ☐	Liver Disease ☐	Hallucinations ☐

If yes, please describe, indicating age, and complications:

BEHAVIOR:

Are you having any problems with your child's behavior? ☐Y ☐N (if yes, please explain)

Do parents agree on methods of discipline? ☐Y ☐N
Describe each of your methods:

Who generally disciplines the child?

Is anyone else (e.g. school, sitter) having problems with your child's behavior? ☐ Y ☐N (if yes, please explain)

What do you like best about your child?

SCHOOL HISTORY:

Please complete the following about your child, beginning with nursery/day care and ending with current placement. (If need more room, use other side of this page)

School	Address	Grade or class placement	Dates of Attendance
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you satisfied with your child's current school placement? ☐Y ☐N (if no, please explain)

Have you ever requested testing from school? ☐Y ☐N (if yes, please explain)

Is any testing scheduled? ☐Y ☐N (if yes, please explain)

Please list the names and addresses of other professionals who have worked with you and your family.

	NAME	COMPLETE ADDRESS
Physician		
Psychologist/Counselor		
Other (please specify)		

Please use this space for any other information you feel will be helpful to us in evaluating your child.