CHILD HISTORY FORM

What is today's date? ______________________________

Who referred you to us? ______________________________

Print the CHILD'S name: ______________________________

Is the child a boy or girl? (Circle one): BOY GIRL

What is the child's date of birth? ______________________________

What is the child's race or ethnic group? Circle one or more:

Anglo Hispanic Black Asian Other

What school does he or she attend? ______________________________

What is the school's phone number? ______________________________

Who may we call at the school? ______________________________

What grade is he or she in? (Circle one):

None	Daycare	Preschool	Kinder	1st	2nd	3rd	4th
5th	6th	7th	8th	9th	10th	11th	12th

Which of the following is he/she in? Circle one:

Regular classes	Alternative school	Advanced classes	CMC (Resource)	Behavioral unit	Life Skills	Home school

Which of the following describes your child best? (Circle one):

- Always plays alone
- Sometimes plays with others
- Usually plays with others
- Always plays with others

Name some GOOD things about the child:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Does your child do any of the things listed below? (Circle one or more):					
Hits others	Bites others	Slaps others	Kicks others	Breaks things	Steals
Bites nails	Pops Knuckles	Can't sit still	Can't stay seated	Threatens others	Threatens to hurt/kill self
Hits self	Bites self	Slaps self	Bangs head	Starts fires	Tries to kill self
Yells	Uses bad words	Threatens	Lies	Interrupts	Can't play quietly
Acts nervous	Acts scared	Is too active	Is sad a lot	Is easily upset	Leaves things half-done
Is easily distracted	Is forgetful	Talks back	Argues	Sleeps more than usual	Sleeps less than usual
Eats more than usual	Eats less than usual	Acts very shy	Talks all the time	Can't make decisions	Talks about death a lot

Does your child do any of the things listed below? (Circle one or more):

Uses Drugs	Is in a gang	Skips school	Runs away	Has few friends	Has no friends
Pulls out own hair	Eats things that aren't food	Wets the bed	Is cruel to animals	Has a lot of nightmares	Sleeps in parents bed
Won't take baths	Is sexually active	Anything else? ____________________ ____________________			

What is the biggest problem?

How long has it been a problem?

What do you think caused it?

What seems to upset the child?

What seems to calm the child?

Please print the name, age, date of birth, and relationship to the child of everybody else who lives with the child. Include yourself if you live there.

Name	Age	Date of birth	Relationship to the child
1			
2			
3			
4			
5			
6			
7			
8			
9			

What is the highest grade the child's MOTHER finished? (Circle one):

None 1 2 3 4 5 6 7 8 9 10 11 12 GED

Some College | 2-year degree | BA | BS | MA | PhD | Other: ________________________

Does she work outside the home? (Circle one):

No | Part time | Fulltime | More than 40 hours per week

What is the highest grade the child's FATHER finished? (Circle one):

None 1 2 3 4 5 6 7 8 9 10 11 12 GED

Some College | 2-year degree | BA | BS | MA | PhD | Other: ________________________

Does he work outside the home? (Circle one):

No | Part time | Fulltime | More than 40 hours per week

Are the child's birth parents: (Circle one or more):

Living together	Separated When?	Divorced When?	Mother died When?	Father died When?
	________	________	________	________
Mother jailed When?	Father jailed When?			
________	________			

Who has legal custody of the child? ____________________

How often did the mother drink Alcohol when she was pregnant with him or her? (Pick the closest answer):

Daily	Weekly	Monthly	Less than monthly	Not at all

Did the mother use any of the things listed below when she was pregnant with the child? (Circle one or more)

Caffeine	Tobacco	Medicine	Herbal medicine	Marijuana
Cocaine	Heroin	________	________	________

How long was the pregnancy?

6 months or less	About 7 months	About 8 months	About full-term	More than 9 months

Were there any complications during pregnancy or labor? YES NO
What happened? ____________________

____

____

How long was the labor? ____________________

How old was the child when he or she first:

Crawled?	Walked?	Said first word?	Talked?
________	________	________	________

Have any of these things happened to your child? (Circle one or more):

Ear infections: When? ___	Meningitis When? ___	Pneumonia When? ___	Fever over 103F/39C: When? ___	Asthma: When? ___	Hayfever: When? ___
Food allergies: When? ___	Skin rashes: When? ___	Eye problems: When? ___	Hearing problems: When? ___	Bowel problems: When? ___	Slow weight gain: When? ___
Anemia (low blood count): When? ___	Heart problems: When? ___	Epilepsy: When? ___	Convulsions when sick: When? ___	Cancer: When? ___	Head injury: When? ___
Poisoning: When? ___	Overdose: When? ___	Hospitalization for illness: When? ___	Surgery: When? ___	Serious injury: When? ___	Kidney problems: When? ___
Urinary problems: When? ___	Got sick after a shot: When? ___	Diabetes: When? ___	Psychiatric exam: When? ___	Psychiatric hospitalization: When? ___	Physical Abuse: When? ___
Sexual abuse: When? ___	Hepatitis: When? ___	HIV: When? ___	AIDS: When? ___	Measles: When? ___	Chicken pox: When? ___
Eating problems: When? ___	Sleeping problems: When? ___	Car accident: When? ___	Pregnancy: When? ___	Death of relative: When? ___	Death of friend: When? ___

Please list all the medicines the child takes:

Name of Medicine	How often does child take it?	How much does the child take each time?
1.		
2.		
3.		
4.		
5.		
6.		

Name of child's doctor: ________________________________

Phone number of child's doctor: _________________________

Date of child's last doctor visit: __________________________

Date of child's last hearing test: __________________________

Date of child's last eye exam: ____________________________

Has the child ever gotten any special medical treatment?

YES What is / was it? ____
Dates of Treatment? ___________________ to ______________________

NO

What language do you usually speak at home? ___________________________

How well does the child speak ENGLISH?

Not at all Very poorly Poorly Well Very Well

How well does the child speak SPANISH?

Not at all Very poorly Poorly Well Very Well

What other language does your child speak? _________________________

Did the child attend DAYCARE?

Not at all	Less than 6 months	6 months to one year	One to two years	More than two years

Did the child attend PRESCHOOL?

Not at all	Less than 6 months	6 months to one year	One to two years	More than two years

Who stays with the child after school? ________________________________

Who stays with the child when he or she is sick? ________________________

Are there family or friends in the area who help with the child? (Circle one or more):

Mom's mother	Mom's father	Mom's brother(s)	Mom's sister(s)	Child's Adult sister
Dad's mother	Dad's father	Dad's brother(s)	Dad's sister(s)	Child's adult brother
Cousin	Friend	Other (who?): ________________		

How is the child disciplined? (Circle one or more):

Talking about it	Sending to room	Taking away things	Grounding	Spanking

Other:

Do the parents usually agree on discipline? YES NO not applicable

What jobs or chores does the child have at home?

____

What does your child like to do for fun?

____

Have any of the child's other relatives on his mother's side ever had nay of the things listed below? (Circle one or more):

Learning Disorder:
Who had or has it? ______________________________

Mental Retardation:
Who had or has it? ______________________________

Hyperactivity:
Who had or has it? ______________________________

Attention Deficit Disorder:
Who had or has it? ______________________________

Depression:
Who had or has it? ______________________________

Bipolar Disorder (Manic-Depressive Disorder):
Who had or has it? ______________________________

Schizophrenia:
Who had or has it? ______________________________

Alcohol abuse:
Who had or has it? ______________________________

Drug abuse:
Who had or has it? ______________________________

Have any of the child's other relatives on his father's side ever had any of the things listed below? (Circle one or more):

Learning Disorder:
Who had or has it? ______________________________

Mental Retardation:
Who had or has it? ______________________________

Hyperactivity:
Who had or has it? ______________________________

Attention Deficit Disorder:
Who had or has it? ______________________________

Depression:
Who had or has it? ______________________________

Bipolar Disorder (Manic-Depressive Disorder):
Who had or has it? ______________________________

Schizophrenia:
Who had or has it? ______________________________

Alcohol abuse:
Who had or has it? ______________________________

Drug abuse:
Who had or has it? ______________________________

Have any of the child's brothers or sisters ever had any of the things listed below? (Circle one or more):

Learning Disorder:
Who had or has it? ____________________

Mental Retardation:
Who had or has it? ____________________

Hyperactivity:
Who had or has it? ____________________

Attention Deficit Disorder:
Who had or has it? ____________________

Depression:
Who had or has it? ____________________

Bipolar Disorder (Manic-Depressive Disorder):
Who had or has it? ____________________

Schizophrenia:
Who had or has it? ____________________

Alcohol abuse:
Who had or has it? ____________________

Drug abuse:
Who had or has it? ____________________