CHILD HISTORY FORM (PARENT)

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Today's Date:	
Name of person completing form: ***(Last, First, M.I.)***	**Relationship to child:**
Child's Name: ☐ **M** ☐ **F**	**Child's DOB:**
Child's Grade:	**Child's Address:**
Home Phone:	**Child's Cell Phone (if applicable):**
Child's Pediatrician:	**Pediatrician's Address and Phone/Fax:**

PARENT INFORMATION

Name of child's mother/main guardian:		
Mother's Age:	**Current employment and educational status**:	
Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**		
What does mother do for work:	**Name of employer**:	
Home address (if different from child):		
Phone and Email:	**Home phone**:	**Email**:
	Work phone:	
	Cell phone:	
List any medical or mental health problems that other doctors have diagnosed		
Name of child's father/main guardian:		
Father's Age:	**Current employment and educational status:**	
Marital status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**		
What does father do for work:		
Home address (if different from child):		
Phone and Email:	**Home phone:**	**Email:**
	Work phone:	
	Cell phone:	
List any medical or mental health problems that other doctors have diagnosed		

CURRENT PROBLEMS

CURRENT CONCERNS			
Please describe the key problems for which you are seeking treatment for your child.			
Approximate date these problems began:			
Problems are:	☐ **Worsening**	☐ **Improving**	☐ **Stabilizing**

FAMILY ENVIRONMENT				
Please indicate below the individuals who live in the home with the child.				
Name	**Age**	**Relationship to child**	**Living at home?**	
			☐ **Yes**	☐ **No**
			☐ **Yes**	☐ **No**
			☐ **Yes**	☐ **No**
			☐ **Yes**	☐ **No**
			☐ **Yes**	☐ **No**
			☐ **Yes**	☐ **No**

Has the child lived with persons other than the parents? ☐ **Yes** ☐ **No** **If so, with whom has the child lived?**

Are the child's parents separated or divorced?	☐**Yes**	**Date of divorce/separation (circle one):**		
		Who has legal and/or physical custody?		
		Are there any pending custody/visitation issues?	☐ **Yes**	☐ **No**
	☐ **No**			

Who is responsible for the majority of caregiving?

Has the family ever been involved in DCYF? ☐ **Yes** ☐ **No** **If yes, please describe.**

Please indicate below whether anyone in the child's family has suffered from emotional problems or mental health difficulties.

	AGE	PROBLEMS		AGE	PROBLEMS
Father			**Grandmother** *Maternal*		
Mother			**Grandfather** *Maternal*		
Siblings	☐ **M** ☐ **F**		**Grandmother** *Paternal*		
	☐ **M** ☐ **F**		**Grandfather** *Paternal*		
	☐ **M** ☐ **F**		**Other:**		
	☐ **M** ☐ **F**				

Please describe the level of tension and conflict in the home:	Between parents	☐ Hi	☐ Med	☐ Low
	Between parents and children	☐ Hi	☐ Med	☐ Low
	Between siblings	☐ Hi	☐ Med	☐ Low
Please describe other aspects of family life that may contribute to or influence the child's problems.				

FRIENDS AND SOCIAL ENVIRONMENT

Does your child have:	☐ More friends that most kids	☐ The same as most kids	☐ Fewer than most kids
How would you describe your child's friendship network?	☐ Many close friends	☐ One or two close friends	☐ No close friends
How much bullying or negativity has your child experienced?	☐ None	☐ Some	☐ A lot

DEVELOPMENTAL AND MEDICAL HISOTRY

Is your child:	☐ Biological	☐ Adopted	☐ Foster	☐ Other
If not biological, at what age did he/she begin living with you?				

Was the child born prematurely?	☐ Yes	☐ No
Were there health issues during pregnancy? If yes, specify:	☐ Yes	☐ No
As an infant, did your child have difficulty feeding, sleeping, or being colicky?	☐ Yes	☐ No
Did you child have difficulty with toilet training?	☐ Yes	☐ No
Did your child have more tantrums that most children his/her age?	☐ Yes	☐ No
Is your child in good physical health? If no, please explain below.	☐ Yes	☐ No
Has your child had any significant medical issues (e.g., seizures, surgeries, broken bones, excessive vomiting). If yes, please specify below.	☐ Yes	☐ No
Does your child have difficulty with concentration and memory? If yes, please describe.	☐ Yes	☐ No
Does your child have difficulty with sleeping? If yes, please describe. On average, how many hours does your child sleep at night? __________	☐ Yes	☐ No
Does your child have a poor appetite or difficulty with eating? If yes, please describe.	☐ Yes	☐ No
Has your child ever intentionally hurt or injured himself/herself (e.g., cut, picked, or burned skin). If yes, please detail below.	☐ Yes	☐ No

Is your child currently thinking a lot about suicide?	☐ Yes	☐ No
In the past, has your child thought a lot about suicide?	☐ Yes	☐ No
Has your child ever attempted suicide or made a suicidal gesture? If yes, please describe.	☐ Yes	☐ No
Has your child ever been so upset that he/she indicated that he/she thought about hurting others? If yes, please describe.	☐ Yes	☐ No
Does your child use non-prescribed drugs, illegal drugs, or alcohol? If yes, please describe type of drug and frequency.	☐ Yes	☐ No
Has your child ever been sexually abused, physically, or emotionally abused at any point in his/her life? If yes, please describe.	☐ Yes	☐ No

List your child's CURRENTLY prescribed medications		
Name the Drug	Dose	Response
List medications that your child has been on IN THE PAST		
Name the Drug	Dose	Response

PSYCHOLOGICAL TREATMENT HISTORY

If your child has been in treatment previously, please complete the table below.					
Therapist's Name	Dates of Treatment	Approx. # of sessions	Type of Treatment	Reason for Treatment	Response
Has your child had any psychological assessments done? ☐ Yes ☐ No If yes, please provide us with a copy.					

SCHOOL ENVIRONMENT AND LEARNING HISTORY

Current School:	Current Grade:	
Town/District:	Teacher's Name:	
School psychologist/social worker's name:		
Does your child have an Individualized Education Plan?	☐ Yes	☐ No
Has the school made special modifications/accommodations for your child (e.g., 504 Plan)?	☐ Yes	☐ No
What are your child's typical grades?		
How does your child get along with teachers?		
Does your child have any other school-related difficulties?		

Please note any significant challenges, problems, or traumas the child has faced that you did not note previously in this packet.

Thank you for completing this questionnaire. We expect that it will be very helpful in developing an organized and effective treatment plan.