

Please list all other people living in your child's home:

<u>Name</u>	<u>Age</u>	<u>Relationship to Child</u>	<u>Health/Problems</u>
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Please list any other people who care for your child a significant amount of time (e.g., grandparent, neighbor, etc):

Please list religious affiliation(s)/spiritual connections of parents & child:

Parental Status:

If partnered, for how long: _____ If married, on what date: _____

If separated or divorced, please give date(s) and on the back of this page explain the circumstances, custody & visitation schedule (if any) and communication status between parents. Additionally, please attach a copy of the custody order.

If a parent is deceased, please give the date and explain the circumstances:

If adopted, please give any relevant information about biological parent history:

Briefly describe your child:

Birth and Toddler History:

Were there any illnesses/complications during the pregnancy with this child?

Total number of pregnancies of biological mother: _____

Were there any miscarriages? _____

(Please explain circumstance(s) on the back of this page)

Which pregnancy was this child? _____

Nature of delivery: _____ Full term _____ Premature _____ Cesarean

How would you characterize the experience?

Child's birth weight: _____ Height: _____

Were there any complications during labor and/or delivery? (circle)

breathing problems, cord around neck, color, jaundice, other (please explain):

Did baby have any complications/problems immediately after birth?

Did the baby have colic and/or feeding problems during the first three months?

How was the baby fed?

Was her/his appetite usually good?

Is her/his appetite good now?

When was s/he weaned and how did s/he respond to this process?

Approximate age: sat alone _____ stood alone _____
crawled/crept _____ walked _____
pulled to stand _____ first talked _____
said 2-3 words _____ fed self _____
dressed self _____

Age at which toilet training began _____

Ended? _____

How did your toddler respond to the training?

Favorite Toy _____

Favorite Food _____

Favorite Person _____

As a baby, was your child (circle one):

intense, interested in her/his surroundings, friendly with strangers, affectionate, attached to an object, overactive, independent, more interested in people, more interested in objects, a self-starter, other:

What is the best family story that characterizes your child as an infant/toddler: (please write on back)

Any history of...

If so, approximate age began?

Head banging _____

Stuttering _____

Breath holding _____

Day soiling _____

Temper tantrums _____

Nail biting _____

Excessive Jealousy _____

Hitting _____

Frequent crying _____

Irritability _____

Excessive thumb sucking _____

Excessive masturbation _____

Age Began

Check if Still Occurring

Hurting self _____

Sleep problems _____

Nightmares _____

Bedwetting _____

Excessive fears _____

Excessive fantasizing _____

Intentionally hurting others _____

Problems going to school _____

Problems making friends _____

How does this child compare with her/his siblings?

During the infant/toddler years, did either parent stay home full or part time? Please explain.

If your child attended day care, at what age? What type of situation was this (e.g., in home, center, etc.)? For how many hours a week?

Preschool/Day Care History (if any):

School attended:

Age _____ Part-time _____ Full-time _____

School attended:

Age _____ Part-time _____ Full-time _____

Who was the primary caretaker of the child at home?

Any difficulties at preschool?

Strengths at preschool:

Medical/Mental Health History:

Has your child had any serious accidents/injuries/illnesses involving such things as (circle); convulsions, high fevers, loss of consciousness, fainting, headaches, chronic fatigue, head injuries, ear problems, meningitis, other:

Did your child ever require hospitalization? If so, please explain:

Current pediatrician's name: _____

Address and Phone Number: _____

When was your child's last complete physical? _____

Any allergies? _____

Any special physical problems? _____

Is your child currently on medication? If so, please explain:

Does your child have any health problems at this time?

Has your child previously seen a therapist? If so, at what age(s)? Whom did s/he see? About how many meetings did the child/family have?

Has your child ever been evaluated by a psychologist privately or through the school system? If so, when, and by whom?

What do you remember of the results/recommendations?

Has any other member of your child's immediate family participated in mental health treatment? If so, please explain. (Please use back of page if needed)

Has your child ever been molested? If so, when and by whom?

Has your child had any abuse prevention/assertiveness training? _____

Would you be interested in further information? Yes _____ No _____

About Your Child:

List any significant life traumas:

List any significant life influences:

How would you characterize your child's relationship(s) with her/his sibling(s)?

What is your child's relationship like with you?

Whom is the child most like, in your family?

Who are the people your child tells secrets, worries, feelings to, in your family?

What discipline methods have you found to be most effective with your child?

What are your child's favorite activities?

What are your child's least favorite activities?

In what after-school activities does s/he participate?

Please list any chores or jobs your child has at home (e.g., paper route, babysitting, making her/his bed, etc):

How well does your child carry out the above chores?

What are your main concerns about your child?

What kind of help do you expect from me in working with your child?

Any other comments:

Name of person(s) completing this form: _____

Date Completed: _____