

*"Focused Solutions For Today's Problems."*

Please fill out this information form as completely as you can. Circle the item number of any questions that should be discussed more fully.

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_

Your Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_

**Family Members**

	Name	Age	In Home	Occupation/Grade
Parents	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
Others	_____	_____	_____	_____
	_____	_____	_____	_____

Does your child have any current problems at school and/or home? \_\_\_\_\_

Please list any previous counseling and/or treatment that your child has had \_\_\_\_\_  
Dates \_\_\_\_\_

**1) What is your child like (check all that apply)**

- |                                       |   |                                       |                                       |                                   |
|---------------------------------------|---|---------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Impulsive    | <input type="checkbox"/> Easily frustrated  | <input type="checkbox"/> Shy          | <input type="checkbox"/> Dependent    | <input type="checkbox"/> Relaxed  |
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Can't ask for help | <input type="checkbox"/> Unhappy      | <input type="checkbox"/> Private      | <input type="checkbox"/> Outgoing |
| <input type="checkbox"/> Sensitive    | <input type="checkbox"/> Often in trouble   | <input type="checkbox"/> Enthusiastic | <input type="checkbox"/> Immature     | <input type="checkbox"/> Quiet    |
| <input type="checkbox"/> Independent  | <input type="checkbox"/> Often tearful      | <input type="checkbox"/> Tense        | <input type="checkbox"/> Distractible | <input type="checkbox"/> Helpful  |
| <input type="checkbox"/> Depressed    | <input type="checkbox"/> Rapid mood changes | <input type="checkbox"/> Happy        | <input type="checkbox"/> Irritable    | <input type="checkbox"/> Friendly |
| <input type="checkbox"/> Disorganized | <input type="checkbox"/> Lacks confidence   | <input type="checkbox"/> Demanding    | <input type="checkbox"/> Restless     | <input type="checkbox"/> Angry    |
| <input type="checkbox"/> Aggressive   | <input type="checkbox"/> Very active        | <input type="checkbox"/> Bossy        | <input type="checkbox"/> Stubborn     | <input type="checkbox"/> Fearful  |

**2) How does your child get along with his/her parents?** \_\_\_\_\_

**3) a. Are there any parent or family conflicts?** \_\_\_\_\_

b. If there have been any parental separations or divorce, please give date(s), name(s) of the parental figures and list which parent(s) has legal custody and primary residential placement. \_\_\_\_\_

**4) How does your child usually react to problems or difficulties?** \_\_\_\_\_

- 5) What kind of discipline works best? \_\_\_\_\_  
\_\_\_\_\_
- 6) Has your child ever been physically or sexually abused? \_\_\_\_\_  
\_\_\_\_\_
- 7) How does your child get along with other children his/her own age? \_\_\_\_\_
- 8) What are your child's positive qualities and personal strengths? \_\_\_\_\_  
\_\_\_\_\_
- 9) What are your child's special interests or talents? \_\_\_\_\_  
\_\_\_\_\_
- 10) Has your child ever had a head injury, seizures, convulsions or loss of consciousness? If yes, please state age. \_\_\_\_\_
- 11) Are there any other medical problems your child has, including allergies? \_\_\_\_\_  
\_\_\_\_\_
- 12) List any medications your child takes including vitamins and nonprescription drugs. \_\_\_\_\_  
\_\_\_\_\_
- 13) Family history of difficulties (check all that apply and list the relationship of family member to the child, include Parents, Siblings, Grandparents, Aunts, Uncles, & Cousins)
- \_\_\_ Mental Illness \_\_\_\_\_
  - \_\_\_ Emotional Problems \_\_\_\_\_
  - \_\_\_ Alcoholism/Drug Abuse \_\_\_\_\_
  - \_\_\_ Behavioral Problems \_\_\_\_\_
  - \_\_\_ Learning Disability \_\_\_\_\_
  - \_\_\_ Retardation \_\_\_\_\_
  - \_\_\_ Legal Problems \_\_\_\_\_
  - \_\_\_ Seizures/Epilepsy/Neurological Problems \_\_\_\_\_

**Developmental History**

Pregnancy & Birth

- 1) Was the pregnancy planned? \_\_\_ yes \_\_\_ no
- 2) What was the family situation during the pregnancy? \_\_\_ happy \_\_\_ unhappy:  
explain \_\_\_\_\_
- 3) What was the mother's condition during pregnancy? (check all that apply)
- \_\_\_ Fevers \_\_\_ over 35 during pregnancy \_\_\_ Diabetes \_\_\_ Smoked
  - \_\_\_ Used Drugs \_\_\_ Under 17 during pregnancy \_\_\_ Toxemia \_\_\_ Drank alcohol
  - \_\_\_ Injuries \_\_\_ Other problems \_\_\_\_\_
- List any medications taken during pregnancy \_\_\_\_\_
- 4) Labor and delivery problems? (check all that apply)
- \_\_\_ Caesarian section \_\_\_ Labor less than 2 hours \_\_\_ Cord around baby's neck
  - \_\_\_ Breech \_\_\_ Labor induced \_\_\_ Mother asleep at delivery
  - \_\_\_ Forceps used \_\_\_ Labor more than 24 hours \_\_\_ Other

5) Birth weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz Condition at Birth: \_\_\_\_\_ OK \_\_\_\_\_ Problems (check all that apply)  
\_\_\_\_\_ Jaundice \_\_\_\_\_ Infection \_\_\_\_\_ Premature \_\_\_\_\_ Anemic  
\_\_\_\_\_ Trouble breathing \_\_\_\_\_ Needed Oxygen \_\_\_\_\_ Trouble sucking \_\_\_\_\_ Birth Defects  
\_\_\_\_\_ Needed surgery \_\_\_\_\_ in ICU \_\_\_\_\_ Hospitalized for more than 5 days  
\_\_\_\_\_ Other Problems \_\_\_\_\_

Infancy (0 – 12 months)

1) Please list any major family events during this time period. For example; deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc. Please include baby's age and general reaction. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Please list any major illnesses, injuries or hospitalizations. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Please describe any feeding/eating difficulties. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4) Please describe any sleeping difficulties. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) What was your baby like? (check all that apply)

\_\_\_\_\_ cuddly \_\_\_\_\_ social \_\_\_\_\_ difficult to soothe  
\_\_\_\_\_ fussy \_\_\_\_\_ quiet \_\_\_\_\_ slow to adjust to change

Toddler Years (12 months to 3 years)

1) Please list any major family events during this time period. For example; deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc. Please include child's age and general reaction. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Please list any major illnesses, injuries or hospitalizations. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Please list any unusual habits, mannerisms or fears. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4) a. How old was your child when he/she spoke his/her first word? \_\_\_\_\_

b. How old was you child when he/she used complete sentences? \_\_\_\_\_

5) At what age did your child 1<sup>st</sup> walk? \_\_\_\_\_

6) a. How old was your child when he/she started toilet training? \_\_\_\_\_

- b. How old was your child when he/she completed toilet training? \_\_\_\_\_  
c. Please list any difficulties. \_\_\_\_\_

7) Did your child have any problems with separation from his/her parents? \_\_\_\_\_

8) Please list any behavioral problems with your child? \_\_\_\_\_

Preschool (ages 3-6) omit if child is under 3

1) Please list any major family events during this time period. For example; deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc. Please include child's age and general reaction. \_\_\_\_\_

2) Please list any major illnesses, injuries or hospitalizations. \_\_\_\_\_

3) Please list any unusual habits, mannerisms or worries. \_\_\_\_\_

4) Please describe how your child gets along with other children. \_\_\_\_\_

5) Please list any behavioral problems with your child. \_\_\_\_\_

6) Is your child fearful of new people and/or new situations? If yes, please explain. \_\_\_\_\_

7) Do you have any special concerns about your child during this age range? Check all that apply and explain below.

- eating problems     sleeping problem     speech problems  
 toileting problems     bed wetting     temper tantrums     other \_\_\_\_\_

8) Please list any daycare and/or babysitting problems. \_\_\_\_\_

9) Did your preschooler exhibit any unusual behavior? (check all that apply)

- quiet     over active     easily frustrated     clumsy  
 usually happy     demanding     often sad or angry  
 often fell     difficulty separating

Middle Childhood Period ( ages 6-11) omit if child is under 6

1) Please list any major family events during this time period. For example; deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc. Please include child's age and general reaction. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Please list any major illnesses, injuries or hospitalizations. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Please list any unusual habits, mannerisms, or worries. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4) Please list name of your child's school(s) and the grades he/she has attended. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) How was your child's adjustment to changing schools? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6) Did you have any problems getting your child to go to school? If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7) Please describe your child's relationship with his/her teachers. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8) Please describe your child's relationship with other children. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9) Does your child have a "best" friend? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10) Please list any problems your child has with attitude towards school or their grades. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11) Did your child repeat any grade? If yes, which grade(s)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12) Did you child attend any special classes? If yes, during which grade and for what reason? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13) Are you or your child's teachers concerned about any of the following? (check all that apply)

- speech                       reading                       writing                       hearing  
 vision                       eye-hand coordination                       behavioral

Please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14) Does your child have any problems or worries about sex? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15) Does your child have any signs of puberty?  menstruation  growth spurt  voice change  
What is your child's reaction to this? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Adolescence (ages 12-19) omit if child under 12

1) Please list any major family events during this time period. For example; deaths, births, parental conflicts, moves, separation from parents, change in primary caretaker, traumatic events, etc. Please include child's age and general reaction. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Please list any major illnesses, injuries or hospitalizations. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3) Please list any unusual habits, mannerisms, or worries. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4) Does your child have any eating problems or problems with weight gain or loss? \_\_\_\_\_

5) Does your child have any problems sleeping? \_\_\_\_\_

6) Does your child have any academic problems at school? \_\_\_\_\_

7) Does your child have any behavioral problems? \_\_\_\_\_  
\_\_\_\_\_

8) At what age did you child experience the following?

Growth spurt \_\_\_\_\_ Voice Change \_\_\_\_\_ Menstruation \_\_\_\_\_

9) Are there any special concerns or reactions to these physical changes? \_\_\_\_\_  
\_\_\_\_\_

10) Do you have any concerns about your child's friends? \_\_\_\_\_

11) Have there been worries or concerns about sex or sexual activity? \_\_\_\_\_  
\_\_\_\_\_

12) Does your child smoke, use alcohol or take drugs? If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_

13) Has your child had any trouble with law/police? If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_

14) Has your child held a job(s)? If yes, please list and note any concerns. \_\_\_\_\_  
\_\_\_\_\_

15) Have there been problems about rules, curfew, where your child goes, etc.? \_\_\_\_\_  
\_\_\_\_\_

16) Has your child gotten into any physical struggles with an adult(s). If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

17) What specific changes would you want to see happen to feel that your therapy experience has been successful? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

18) Is there anything else that would be helpful to know about your child or family? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for your attention to this detailed history.