Child and Family History Form

*If you need more space to answer any of the questions on this form, please indicate next to that question and use the reverse page.

1. General Information

Child’s Name ________________________________ Date of Birth _____/ _____/ _____

Date of Evaluation _____ / _____ / _____ Age _______ Grade (if in school) ____________

Person(s) completing this form and the relationship to the child: ________________________________

Who suggested this evaluation? ____________________________________________________________

Has your child had a previous psychological evaluation, counseling or psychotherapy?
Yes [ ] No [ ]

If yes, please list therapist/evaluators and approximate dates seen: ____________________________________________________________

Please list your child’s strengths, interests and hobbies: _________________________________________

____________________________________________________________________________________

What are you hoping to gain from this evaluation? _________________________________________

____________________________________________________________________________________

Name and phone # of your child’s pediatrician: ________________________________

____________________________________________________________________________________

Name and phone # of your child’s teacher and/or school counselor: ___________________________

____________________________________________________________________________________

Name and phone # of other important professional contacts in your child’s life: ______________________

____________________________________________________________________________________

____________________________________________________________________________________

Have you filled out the exchange of information form? Yes ___ No ___
2. Your Child’s Family History

List all people currently living in child’s household(s) and their relationship to the child.
(If child lives in two homes, list both and specify the amount of time in each home):

__________________________________________________________________________________________
__________________________________________________________________________________________

List others who are not living in the home but who are actively involved with your child:

__________________________________________________________________________________________

Parent(s) current relationship status:
Married □ Never Married □ Separated □ Divorced □
Remarried □ Widowed □ Other (specify) □ ________________________________

If divorced, separated or never married, what is your custody agreement?
Joint Legal, Joint Physical □ Sole Legal, Sole Physical □
Joint Legal, Sole Physical □ Other (specify) □ ________________________________

Child’s age at time of separation _____ Child’s age at time of divorce _____

If divorced or separated, are both parents consenting to this evaluation/treatment?
Yes □ No □

If no, please explain _________________________________________________________________

__________________________________________________________________________________________

Are there any concerns or events that have occurred within the family that may be important to know about when working with your child? _________________________________________________________________

__________________________________________________________________________________________

What has been helpful and/or not helpful to your family in dealing with these concerns? __________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Have there been any community resources that have been useful to your family? __________________

__________________________________________________________________________________________
3. Child’s Developmental History
We appreciate the diversity and complexity of families today. Please complete the following as best describes your family’s history and experience.

This is my:  Adopted child  □  Biological child  □  Foster child  □
Stepchild  □  Other  □  (specify)  ________________________

3a. If your child is a adopted or is a foster child, please complete this section. If not, please skip to section 3b.

Age of child when they joined adoptive or foster family: ________________________________

Child’s Birth place: ________________________________

If adopted, was this adoption: International  □  or Domestic  □

If available, knowledge of pre-adoptive or pre-foster placement: ________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Is there any medical/psychological information about child’s birth parents that would be helpful to know?

____________________________________________________________________________________

____________________________________________________________________________________

Age of adoptive or foster parent(s) when child joined adoptive or foster family: ________________________________

Does the child currently have contact with their birth parent(s)?

Yes  □  No  □

If yes, what is the contact agreement? ________________________________

____________________________________________________________________________________

What is your child’s understanding of their adoption or foster placement? ________________________________

____________________________________________________________________________________

____________________________________________________________________________________
3b. Prenatal History  *(Adoptive and foster parents, please complete if you have access to this information)*

Age of parent(s) at time of birth of this child: ___________________________________________________
________________________________________________________________________________________

Number of prior pregnancies: _____________  Number of miscarriages: _______

Were there any medical problems with this pregnancy? ________________________________
________________________________________________________________________________________

Did the mother have any problems with labor and/or delivery? _____________________________
________________________________________________________________________________________

Length of pregnancy: _______ weeks

Were there any of the following medical problems?

Toxemia  □  Diabetes  □  Bleeding  □  High blood pressure  □  Other  □ (specify)___________

During pregnancy, did mother take any medications and/or substances?

Yes  □  No  □

If yes, please list all medication and/or substances? _________________________________________
________________________________________________________________________________________

3c. Early Childhood History

Child’s health at time of birth:

- Weight _____  Apgar score (if known) _____  
- Trouble breathing _____  Jaundiced (got yellow) _____  
- Seizures _____  Cyanotic (turned blue) _____  
- Was very jittery _____  Fever _____  

How old was your child when they:

- Sat up without help _____  Walked without help _____  
- Spoke first word _____  Spoke 2-3 word sentence _____  
- Bladder trained _____  Bowel trained _____

Child’s hand preference:  Left □  Right □  Both □

Please describe any other difficulties that your child may have had as a newborn or during early childhood
________________________________________________________________________________________
________________________________________________________________________________________
Did your child have any of the following difficulties?  Yes □ No □

*If YES,* please check the appropriate box to indicate age.

<table>
<thead>
<tr>
<th></th>
<th>0-3 Mos.</th>
<th>3-12 Mos.</th>
<th>1-3 Yrs.</th>
<th>3-6 Yrs.</th>
<th>6+ Yrs.</th>
<th>Currently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficult to comfort</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Colic</td>
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<tr>
<td>Problems feeding</td>
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<tr>
<td>Poor appetite</td>
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<tr>
<td>Trouble falling asleep</td>
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<tr>
<td>Trouble staying asleep</td>
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<tr>
<td>Excessive activity level</td>
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<tr>
<td>Temper tantrums</td>
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<tr>
<td>Fears/worries</td>
<td></td>
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<tr>
<td>Odd or unusual interests</td>
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</tbody>
</table>

Please briefly describe any difficulties noted above: ___________________________________________

____________________________________________________________________________________

Does anyone in your child’s family have the following difficulties?  Yes □ No □

*If YES,* please check and list **WHO** they are (e.g., mother, father, sister, paternal grandmother, maternal uncle and note with a “B” if this person is biologically related to the child).

<table>
<thead>
<tr>
<th>WHO</th>
<th>Parent</th>
<th>Parent</th>
<th>Sibling</th>
<th>Grandparent</th>
<th>Aunt/Uncle</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trouble with school</td>
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<tr>
<td>Behavior problems</td>
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<tr>
<td>Repeated grade</td>
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<tr>
<td>Mental retardation</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Anxiety</td>
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<tr>
<td>Suicidal behavior</td>
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<tr>
<td>Hyperactivity/attention problems</td>
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<tr>
<td>Drug/alcohol Problems</td>
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<tr>
<td>Schizophrenia</td>
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<tr>
<td>Bipolar (manic depressive) disorder</td>
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<tr>
<td>Tics or Twitching</td>
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</tbody>
</table>
3d. Your Child's Current Health:
Please indicate if your child has any of the following (*please explain all “Yes” answers*)

**Allergies?**
- Yes [ ] No [ ]
*If yes, please list everything that your child is allergic to:*
____________________________________________________________________________________________

**Allergies to medication?**
- Yes [ ] No [ ]
*If yes, please list all of the medications that your child is allergic to:*
____________________________________________________________________________________________

**Asthma?**
- Yes [ ] No [ ]

**Stomachaches?**
- Yes [ ] No [ ]

**Lead poisoning?**
- Yes [ ] No [ ]

**Head injuries?**
- Yes [ ] No [ ]

**Headaches?**
- Yes [ ] No [ ]

**Seizures?**
- Yes [ ] No [ ]

**Ear infections?**
- Yes [ ] No [ ]

**Vision problems?**
- Yes [ ] No [ ]

**Sleep disturbance?**
- Yes [ ] No [ ]

**Does your child snore?**
- Yes [ ] No [ ]
*Please describe your child’s sleep habits:*
____________________________________________________________________________________________

**Any other health concerns?***
____________________________________________________________________________________________

**Is your child currently on medication?**
- Yes [ ] No [ ]
*If yes, please list the medication name, dosage(s), and any side effects:*
____________________________________________________________________________________________

**Has your child taken psychiatric medication in the past?**
- Yes [ ] No [ ]
*If yes, to the best of your ability, please list the names, doses, and impact/side effects on the back of this page.*

Please list any hospitalizations (medical and psychiatric). Indicate dates. ______________________________________________________________
3e. Your Child's School's History

Did your child attend nursery school/daycare?  Yes □ No □  If yes, age started: ____________________

Please list any concerns at that time: ____________________________________________________________
_________________________________________________________________________________________

Were there any concerns at kindergarten screening?  Yes □ No □

__________________________________________________________

Please list all schools your child has attended and at what age and grade ______________________________
_________________________________________________________________________________________

If your child has a favorite subject, what is it? __________________________________________________

If there is a particular subject(s) that your child dislikes or has difficulty with, please list: ______________

Has your child ever experienced any of the following difficulties in school?

Learning challenges □  Social difficulties □  Behavioral difficulties □  Emotional difficulties □

If yes, when were these difficulties first noticed? Please describe: ________________________________
_________________________________________________________________________________________

If yes, has your child been evaluated at school for any of these difficulties? ________________________
_________________________________________________________________________________________

Has your child received special help in the past?  Yes □ No □

Is your child currently receiving special help?  Yes □ No □

If yes to either question, please describe the type of help received and who provided it:
________________________________________________________________________________________
________________________________________________________________________________________

How does your child currently feel about going to school?

Extremely unhappy 1 __ 2 __ 3 __ 4 __ 5 __ Extremely happy

Does your child receive homework assignments? If so please note completion rate:

Almost never 1 __ 2 __ 3 __ 4 __ 5 __ Always

How difficult does your child find schoolwork?

Very difficult 1 __ 2 __ 3 __ 4 __ 5 __ Easy

Describe your child’s relationship with his or her current classroom teacher(s).

Negative 1 __ 2 __ 3 __ 4 __ 5 __ Positive

Please describe how your child spends time after school: _________________________________________
3f. Your Child’s Social History

Has your child experienced any major losses and/or separations? Yes ☐ No ☐

*If yes,* please provide details: ___________________________________________
________________________________________

In the past, has your child had difficulties separating from familiar people?

Yes ☐ No ☐

Is this still a problem? Yes ☐ No ☐

*If yes to either,* please describe: _______________________________________
________________________________________

Does your child seek out friends? Yes ☐ No ☐

Do peers seek out your child? Yes ☐ No ☐

Does your child play primarily with children their own age? Yes ☐ No ☐

Does your child fight frequently with peers? Yes ☐ No ☐

Do you have any concerns about your child’s friendships? Yes ☐ No ☐

*If yes,* please explain ______________________________________________________
________________________________________

What are three strengths that best describe your child? _____________________________

How does your child spend their free time? _______________________________________

What activities does your child enjoy doing the most? _____________________________

For parents of preteens and teens:

Does your child have a curfew? Yes ☐ No ☐ N/A ☐

Does your child adhere to curfew? Yes ☐ No ☐ N/A ☐

Does your child date? Yes ☐ No ☐ N/A ☐

What is your teen’s exposure and/or attitude toward drugs, nicotine, alcohol? ________________

Is it of concern to you? _____________________________
### 3g. Your Child’s Temperament

Please circle the number that best corresponds to your child’s temperament for each category:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>1 2 3 4 5 6 7</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIVITY LEVEL</td>
<td>highly active, always seems to be &quot;on the go&quot;</td>
<td>1 2 3 4 5 6 7</td>
<td>calm and content, inactive most of the time</td>
</tr>
<tr>
<td>ADAPTABILITY</td>
<td>adapts easily to change</td>
<td>1 2 3 4 5 6 7</td>
<td>does not adapt easily to change</td>
</tr>
<tr>
<td>REGULARITY</td>
<td>eating, sleeping, and bathroom habits are regular</td>
<td>1 2 3 4 5 6 7</td>
<td>eating, sleeping, and bathroom habits are irregular</td>
</tr>
<tr>
<td>SENSORY THRESHOLDS</td>
<td>bothered by external stimuli such as loud noises, bright lights, or food textures</td>
<td>1 2 3 4 5 6 7</td>
<td>tends to ignore external stimuli such as loud noises, bright lights, or food textures</td>
</tr>
<tr>
<td>DISTRACTIBILITY</td>
<td>easily distracted, unable to ignore distractions</td>
<td>1 2 3 4 5 6 7</td>
<td>highly focused, not easily distracted</td>
</tr>
<tr>
<td>MOOD</td>
<td>overall positive mood, usually pleasant and happy</td>
<td>1 2 3 4 5 6 7</td>
<td>overall negative mood, often angry, cries often</td>
</tr>
<tr>
<td>PERSISTENCE</td>
<td>sticks with projects until they are done, doesn’t give up</td>
<td>1 2 3 4 5 6 7</td>
<td>does not stick with projects until they are done, gives up easily</td>
</tr>
<tr>
<td>INTENSITY</td>
<td>emotional reactions are intense, even exaggerated</td>
<td>1 2 3 4 5 6 7</td>
<td>emotional reactions are mild, low-key</td>
</tr>
<tr>
<td>APPROACH/</td>
<td>willing to try new things, comfortable in social</td>
<td>1 2 3 4 5 6 7</td>
<td>unwilling to try new things, withdraws in social</td>
</tr>
<tr>
<td>WITHDRAWAL</td>
<td>situations</td>
<td></td>
<td>situations</td>
</tr>
</tbody>
</table>

Comments on your child’s temperament: _____________________________________________________
__________________________________________________________________________________
____________________________________________________________________________________
___________________________________________________________________________________
3h. Your Child’s Cultural/Ethnic/Religious History

The information below may help us understand important influences in your child’s life. Please answer the questions below to the extent that you feel comfortable doing so.

What is important for your provider to know about your family’s ethnic/cultural background?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

How would your child describe their ethnic/cultural identity?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What language (or languages) is spoken at home?
____________________________________________________________________________________

What language is your child most comfortable speaking?
____________________________________________________________________________________

What (if any) is your child’s religious upbringing and current practice?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

How would your child describe their gender identity and sexuality?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have your child and/or family experienced stress related to sexuality, gender, ethnicity and/or cultural/religious practice?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please feel free to include any information that has not been directly requested that you feel may be relevant to a biographical history of your child:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________