Thank you for taking the time to fill out this form, all information is confidential.

Today's Date:

Child's Name: _____ Date of Birth:_____

Person completing questionnaire/relationship to child:_____

How did you hear about us?:_____

Why did you come in to see me today?

How long have you had these concerns?

What have you done in the recently or in the past to try and help with your concerns?

Developmental History:

Was this a planned pregnancy? Yes No Was the pregnancy full term? Yes No

Were there any complications during the pregnancy?_____

Was there any exposure to anything harmful during the pregnancy? Yes No (If so please list):
_____

Were there any complications during delivery? Yes No (if so please list):
_____

Childs birth weight:_____ Length at birth:_____

How old was the child when they first:

Crawled: _____ Walked: _____ Sat up alone: _____

Talked:_____ Was toilet trained: _____

Home Life:

Who does the child live with? _____ Parent's Marital Status:_____

Please describe current relationship between biological parents:_____

	Name	Age	Occupation	Education Level
Mother				
Father				
Step-parent				
Step-parent				

Siblings (please list all siblings, even if child has no contact):

Name	Age	Sex	Do they live with the child? If not where do they live?

Medical History:

Current Primary Care Provider: _____ Phone number:_____

Date of last visit:_____ Reason for last visit:_____

Any current medical problems:_____

Any significant childhood illnesses/injuries:_____

Please list all current medication (both prescribed and over the counter):

Medication	Dosage	For	Prescribed by	Any side effects?

Allergies (to medication or otherwise): _____

Substance use concerns:

Are there any concerns about substance abuse? Yes No

If yes, what substances has the child used?

Alcohol Marijuana Cocaine Heroin Methamphetamines Inhalants Other

Has the child ever been in treatment for substance use problems? Yes No

Psychological History:

	Psychological/Emotional/Substance Use Issues (depression, anxiety, ADHD, alcoholism)	Any Treatment	Hospitalizations for emotional/psychological/substance use
Mother			
Father			
Siblings			
Other relatives			

Please list all previous counseling, psychiatric hospitalization, or psychological evaluations for this child:

Dates	Provider	Focus/purpose of treatment	Do you feel this was helpful?

Has your child ever made a suicide attempt? Yes No If yes when?_____

What happened?

_____

_____

Are you aware of any abuse? (physical/sexual/emotional):

Legal History:

Please list all contacts with law enforcement:

Date	Reason for contact	Outcome

Are there any current legal involvements, including custody disputes or civil actions, for this child? Yes No

_____

Educational History:

Current School: _____ Grade Level: _____

Teacher's Name:_____ School Counselor's Name:_____

How is the child doing in school?_____

School History:

	Name	Dates

Preschool		
Elementary		
Middle school		
High School		

Has your child experienced any of the following?: mark with an X

	Difficulty making friends		Participated in extracurricular activities (sports/clubs)
	Teased/bullied by others		Difficulty concentrating in class
	Suspended or expelled		Tutoring
	Physical fighting		Attended a special program
	Repeated a grade		Failed a class
	Truancy/skipping class		Changed schools due to a move
	Refused to go to school		Attended preschool
	Skipped a grade		Tested for learning problems/ADHD

What does your child enjoy doing?

What are your child's greatest strengths?

Is there anything else you feel I should know about your child?