CLINICAL HISTORY: CHILD

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The following form has been developed to assist your child's therapist in more quickly and thoroughly obtaining information which may be helpful and necessary in assessing the needs of your child and the family. Please answer questions as best and thoroughly as possible. I recommend that each parent, if applicable, completes this in different pen colors so as to provide as much information and perspective as possible. Not all questions will apply to your child's age and stage of development. All information will, of course, be kept confidential.

Child's Name:_____ Date of Birth: _____

Today's Date: _____ Person(s) Filling Out This Form:_____
_____

Name of Child's Current School: _____ Grade: _____

Teacher's Name: _____
Previous Schools (including nursery or preschool): _____
_____
_____

Is or was the child in day care or an after school program? _____
Describe the child's general health: _____
_____
_____
_____

Are there any medical conditions currently being treated? If so, please describe, and include treating physician's name: _____
_____
_____

Do you have any other concerns regarding your child's health? _____
_____
_____
_____

Any history of head injury or trauma?_____

Describe the pregnancy and birth with this child (for example: Cesarean birth, stressful pregnancy/delivery, relaxed pregnancy, ill much of the time, any birth trauma etc.):

_____
_____
_____

Were alcohol or drugs taken by the child's mother during the pregnancy?_____

How would you describe this child as an infant? (for example: fretful, cuddly, active, colicky, difficulty with nursing or feeding)_____
_____

Describe your child's strengths…your family's strengths_____
_____
_____
_____

Circle any of the following that apply to your child:

Headaches (location?)		eating problems
stomach aches	difficulties getting to sleep	daytime wetting
soiling	frequent cuts, bruises, injuries	fussy eater
sleepwalking	nightmares	frequent masturbation
dizzy/fainting spells	frequent vomiting	frequently tired
sleeping too much/too little		allergies (please specify)
complaints of genital itching, soreness		bed wetting

Please explain any of the above items you have circled:_____
_____
_____

Please check any of the following which apply to your child:

_____ Tired, lethargic much of the time
_____ History of being hospitalized (Please specify when _____ reason(s)_____
_____
_____ Difficulty remembering things
_____ Easily distracted by noises, people etc.
_____ Starts many new things without finishing any
_____ Quick to react on impulse rather than thinking first
_____ Does things without considering the consequences

_____ Noisy and talkative
_____ Voice is generally loud
_____ Does not take no for an answer, pesters and does not give up
_____ Expects others not to be displeased by own misbehavior
_____ Attracted to and gets drawn into other's mischief
_____ Disobeys frequently and needs supervision with constant reminding
_____ Has difficulty following more than 2 commands or requests (shut off the TV, put your clothes into the hamper, brush your teeth, and take a shower)
_____ Wants the rules changed and to be the exception
_____ Regressive behavior (example: acts like a baby)
_____ Friends are much younger or older than child's age
_____ Trouble planning and getting organized

_____ Easily angered, temper tantrums
_____ Child is mean, harms animals
_____ Daydreams or seems "spaced-out"
_____ Seems to put self in dangerous situations or does "daredevil" acts
_____ Seems to run and move all the time/fidgety
_____ Rapid and/or extreme changes in mood (happy to angry in a short time span)
_____ Low self-confidence, does not like self
_____ Has few friends or difficulties making friends
_____ Difficulty separating from mother or primary caretaker
_____ Temper tantrums or rages which are long lasting (up to several hours)
_____ Seems sad or depressed
_____ Child talks about death and/or wanting to die or hurt self
_____ Blames self frequently
_____ Hoards food
_____ Sleeps hot
_____ Has many ideas at once
_____ Has horrendous nightmares
_____ Deflects blame onto others
_____ Interrupts others/intrudes often
_____ Periods of self-doubt and self-blame

_____ Silliness, goofiness…frequently, and difficulty stopping
____ Refusal to eat, unusual food preferences (example: only likes crispy foods, or soup or soft foods)
_____ Seems to eat large quantities of food at one time, preoccupation with food
_____ Eats mostly/prefers sweets or carbohydrates

_____ Talk of not liking body, feeling “fat”, and/or dieting
_____ Refusal to eat certain types of food
_____ Leaving the diner table immediately after eating and/or going to the bathroom immediately after eating on a regular basis, refusal to eat with others

_____ Frequent and/or explicit “potty talk”
_____ Sexual behavior
_____ Persistent interest in sex, sexual material
_____ Seems to startle easily, jumpy and/or reactive
_____ Becomes suddenly fearful or anxious especially with sounds, or when touched
_____ Touching self or others in a sexual manner

_____ Performs behaviors or rituals over and over in a certain way, play always must be the same
_____ Picks at body/self
_____ Pulls-out hair, eyelashes, eyebrows, twirls hair constantly, or pulling pet hair

_____ Sudden changes in school grades
_____ Evidence of alcohol/drug use by child (frequent use of eye drops, loss of appetite but craving sweets, room deodorizer or incense)
_____ Sudden change in friends, manner of dress
_____ Secretive behavior
_____ Frequent missed school days, truancies

_____ Child is especially sensitive to touch (being touched, particular about clothing or bed clothes being too scratchy/heavy/rough/or warm/cold?)
_____ Fussy about footwear, especially how socks fit and feel and/or tags on clothing
_____ Child spins around, likes getting dizzy
_____ Child especially does not like movement or spinning
_____ Particular sensitivities to noise (puts hands over ears, gets easily frightened by sounds), or smells, or light (prefers the dark or dim lighting)
_____ No particular hand established as dominant (right or left handed)
_____ Avoidance or difficulty in using small objects like scissors, pencil, crayons
_____ Overreacts or under reacts to painful experiences (really seems to notice/get upset, not at all)
_____ Avoids or really craves messy play or activities
_____ Has poor motor coordination (difficulty going up/down stairs)
_____ Seems accident prone
_____ Often squints, rubs eyes, gets headaches after reading
_____ Often rocks back and forth
_____ Constantly seems to be touching everything (objects, people..) or keeps hands in pockets and does not touch much or like to be touched/hugged, not a cuddler
_____ Difficulty getting dressed
_____ Current/past difficulty with being moved from one position to another (getting in-out of car seat for example)
_____ Trouble screening-out background noises, complains that some certain sounds “hurt”, and/or history of ear infections?_____
_____ Trouble remembering facts/numbers (learning their telephone number or basic Math facts, or following verbal instructions)
_____ Trouble taking oral tests

_____ Avoidance of engaging in conversations especially if there is background noise Like a T.V. or radio or other people talking
_____ Sensitive to sounds
_____ Difficulty riding in a car, discomfort with being upside down or feet leaving the ground
_____ Twirls/spins self frequently
_____ Prefers using fingers to silverware
_____ Trouble learning to ride a bicycle
_____ Difficulty using scissors (elementary age up)
_____ Exceptionally verbal
_____ Difficulty understanding complex reading material

_____ Bowel/Bathroom problems, frequently constipated or wets bed/pants

Please describe any fears which your child may express or have (example: fear of strangers, the dark, spiders etc.):_____
_____
_____

In the past, the family has experienced: Please Check
_____ Financial difficulties **Put a *star in addition if occurred within**
_____ Frequent marital arguments **the past year**
_____ Job change(s)
_____ Move(s) in residence. When? _____
_____ New family member(s)
_____ Death(s) in the family. Date, who?: _____
_____ Legal problems
_____ Death(s) of a pet. Pet name: _____
_____ Change in marital status
_____ Domestic violence (verbal, emotional, physical, sexual). Police involvement?____
_____ Physical illness or injury. Who, specify type:_____
_____ Hospitalization. Date, who: _____
_____ Changes in school (teacher left, new school, etc.)
_____ Changes in living arrangements (boyfriend/girlfriend moved-in or out, step-sister or brother moved-in or out, grand parent moved- in or out, changes in custody or visitation arrangements etc) Please specify:_____
_____
_____

FAMILY HISTORY: Please indicate if any of the following are or have been present for the child's **close biological** relatives:

_____ History of alcohol/drug abuse
_____ Anxiety problems
_____ Obsessessive Compulsive Disorder (OCD)
_____ Super sensitivity to sounds, touch, light
_____ Hospitalization (s) for psychiatric disorder

_____ Serious changing moods or diagnosed with manic depression or bipolar disorder
_____ Schizophrenia
_____ Eating disorder(s)
_____ Family member(s) with a history of dieting and/or weight fluctuations, and/or preoccupation with food
_____ Depression/Bipolar Disorder
_____ Attention Deficit Disorder (ADD/ADHD)
_____ Teasing in the family about body appearance, weight/contests to loose weight
Other family history of importance: _____
_____
_____

Please describe any other concerns and questions you may have regarding this child and/or your
family:_____
_____
_____