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History Form - Child

Child's Name: _____ Age: _____ Today's Date: __/___/___

Address: _____ City: _____

State: _____ Zip/Postal Code: _____

How long at this address? _____

Child's Sex: _____ Child's Birthplace: _____ Birthdate: ____/_____/_____

Person Completing this form: _____ Relation to child: _____

Father's Name: _____ Age: _____ Education: _____

Name of Employer: _____ Work Phone: _____

May I contact you at this work #? ☐ Yes ☐ No May I leave a message? ☐ Yes ☐ No

Type of Work: _____ Home Phone: _____

May I contact you at your home #? ☐ Yes ☐ No May I leave a message? ☐ Yes ☐ No

E-mail address: _____ Cell Phone: _____

May I contact you on your cell phone? ☐ Yes ☐ No May I leave a message? ☐ Yes ☐ No

Mother's Name: _____ Age: _____ Education: _____

Name of Employer: _____ Work Phone: _____

May I contact you at your work #? ☐ Yes ☐ No May I leave a message ☐ Yes ☐ No

Type of Work: _____ Home Phone: _____

May I contact you at your home #? ☐ Yes ☐ No May I leave a message? ☐ Yes ☐ No

E-mail address: _____ Cell Phone: _____

May I contact you on your cell #? ☐ Yes ☐ No May I leave a message? ☐ Yes ☐ No

Please describe the problems for which help is needed at this time.

Has this child ever received mental health treatment (including psychotherapy or prescribed psychiatric medication)? ☐ Yes ☐ No

If yes, please complete the following history of psychiatric/psychological treatment (including psychiatric medication prescribed by a non-psychiatrist physician such as a pediatrician).

Name of Organization/ Professional	Date	Address

Current Family Stressors: Please include things such as recent death in family, caregiver relationship problems, financial problems, serious medical or psychiatric illness, job problems or unemployment, domestic violence…

Trauma: Please include any traumas impacting this child such as witnessing domestic or other violence, sexual, physical or emotional abuse of this child, neglect, or accidents where this child or someone was badly hurt…

If this child has ever experienced sexual, physical or emotional abuse, or neglect, to your knowledge has Child Protective Services ever been contacted or investigated a claim?

☐ Yes ☐ No ☐ Not Applicable

If yes, is there currently an open case with Child Protective Services involving this child? Please provide details.

_____

_____

_____

_____

_____

Psychiatric Medication History

Has this child ever taken psychiatric medications? ☐ Yes ☐ No

If No, please go to page 4 and continue with therapy history.

If Yes, please complete the following.

Space is provided, if necessary for up to 8 psychiatric medication periods on the next two pages.

	Medication	Medication
Drug Name		
Given by Whom		
When Started		
When Stopped		
For What Problems		
Dose		
Benefits		
Side Effects		
Results		

	Medication	Medication
Drug Name		
Given by Whom		
When Started		
When Stopped		
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	Medication	Medication
Drug Name		
Given by Whom		
When Started		
When Stopped		
For What Problems		
Dose		
Benefits		
Side Effects		
Results		

Therapy History:

Has this child ever received mental health related therapy? ☐ Yes ☐ No ☐ Don't Know

If No, please go to page 6.
If Yes, please complete the following:

Please use the following chart(s) to describe all therapies this child has received previously. Space is provided, if necessary for up to 4 therapy descriptions.

	Therapy	Therapy
Type of Therapy		
Given by Whom		
For What Problems		
When Started		
When Stopped		
How Often		
Benefits		
Adverse Reactions		

	Therapy	Therapy
Type of Therapy		
Given by Whom		
For What Problems		
When Started		
When Stopped		
How Often		
Benefits		
Adverse Reactions		

Who referred you to Dr. Labat?

Name: _____ Address: _____

Child's Primary Residence: ☐ Single Parent Home ☐ Two Parent Home ☐ Other:

_____

Within the primary residence, child is living with: ☐ Both biological parents ☐ Biological Father
☐ Biological Mother ☐ Other: _____

Other Children (living with this child):

Name and age: _____ Name and age: _____
Name and age: _____ Name and age: _____
Name and age: _____ Name and age: _____
Other relatives or persons living in the home: _____
This child has how many total: _____ older siblings _____ older half-siblings
_____ younger siblings _____ younger half-siblings

Is this child adopted? ☐ Yes ☐ No
If yes, please describe the circumstance of the adoption:

_____
_____
_____
_____

_____

Marital Status of Primary Caregiver(s):

☐ Married (How long? _____)

☐ Divorced (How long? _____)

If divorced, who has custody? ☐ Mother ☐ Father ☐ Joint Custody

☐ Neither Specify:_____

☐ Separated (How long? _____)

☐ Single

School Information:

Name of School: _____ Phone Number: _____
School Address: _____ Current Grade (1st, 2nd, 11th …) _____
_____

List Previous Schools and dates attended:

_____
_____
_____
_____

_____
_____

Grades repeated: _____ Grades skipped: _____

Expelled? ☐ Yes ☐ No If yes, # of times? _____

Any known learning disabilities? ☐ Yes ☐ No
If yes, please explain:
_____
_____

How does the school describe this child's current behavior?_____
_____
_____
_____

What does this child do best in at school? _____
_____
_____

Which of the following problems, if any, does this child have in school?

☐ Poor handwriting	☐ Poor spelling	☐ Poor math
☐ Poor reading skills	☐ Forgets assignment	☐ Messy and disorganized
☐ Does not remain seated	☐ Incomplete class work	☐ Poor attention in class
☐ Noncompliant in class	☐ Talks out inappropriately in class	☐ Distracted
☐ Test anxiety		☐ Makes many careless errors
☐ Problems with written language		☐ Excessive time to complete assignments

Which of the following, if any, describe(s) this child's interactions with peers?

☐ No friends	☐ Few friends	☐ Loses friends
☐ Mean, aggressive	☐ Too shy or too timid	☐ Trouble making new friends
☐ Bossy, controlling	☐ Risky behaviors	

Please provide any additional comments on homework, academic functions, and peer relations:
_____
_____
_____
_____
_____
_____

Family Medical History:
Do medical illnesses run in the family? (examples: seizures, thyroid problems, allergies) ☐ Yes ☐ No
If yes, please describe:
_____
_____
_____

Pregnancy

Was the pregnancy with this child under a doctor's care? ☐ Yes ☐ No ☐ Don't Know

Check any that apply for this pregnancy:

	Describe
☐ Anemia	
☐ Elevated Blood Pressure	
☐ Toxemia	
☐ Swollen Ankles	
☐ Kidney Disease	
☐ Bleeding	
☐ Measles	
☐ German Measles	
☐ Flu	
☐ Strep Throat	
☐ Other Viruses	
☐ Other Illness	
☐ Nausea or Vomiting	
☐ Injury	
☐ Medication(s) Taken	
☐ Emotional Problems	
☐ Threatened Miscarriage	
☐ Premature Labor	
☐ Severe Emotional Distress	
☐ Smoked During Pregnancy	
☐ Alcohol Use During Pregnancy	

Birth History:

Mother's age at time of child's birth: _____ years

Father's age at time of child's birth: _____ years

How long from first contractions to birth? ____ hrs.

What did the child weigh at birth? __ lbs. ___oz.

Was the mother given medication during childbirth? ☐ Yes ☐ No ☐ Don't Know

Was the mother under anesthesia during childbirth? ☐ Yes ☐ No ☐ Don't Know

If yes: ☐ General ☐ Spinal ☐ Don't Know

Labor

Was labor induced? ☐ Yes ☐ No ☐ Don't Know

If yes, was induced labor planned? ☐ Yes ☐ No ☐ Don't Know

Was this a breech (feet first) delivery ☐ Yes ☐ No ☐ Don't Know

Was the delivery unusual in any way? ☐ Yes ☐ No ☐ Don't Know

If yes, how?

_____

_____

Did the mother have a cesarean section? ☐ Yes ☐ No ☐ Don't Know

If yes, describe any complications:

_____

_____

Was it a multiple birth (twins, triplets, etc?
If yes, which child was born first? _____

At birth, did this child have:

breathing problems?	☐ Yes	☐ No	☐ Don't Know
cord around the neck?	☐ Yes	☐ No	☐ Don't Know
normal color?	☐ Yes	☐ No	☐ Don't Know
If no, what color? ☐ Yellow ☐ Blue			
oxygen used?	☐ Yes	☐ No	☐ Don't Know
If yes, for how long? _____			
Was this child premature?	☐ Yes	☐ No	☐ Don't Know
If yes, how much? _____			
Was it necessary to keep the child at the hospital longer than usual after birth?	☐ Yes	☐ No	☐ Don't Know
If yes, how long after? _____			
Were there problems with feeding?	☐ Yes	☐ No	☐ Don't Know

If yes, please describe:

_____

_____

Was the child normally active as a baby? ☐ Yes ☐ No ☐ Don't Know

Developmental History:

Motor Development (Sitting, Crawling, Walking)	☐ Normal	☐ Fast	☐ Slow	☐ Don't Know
Speech and Language	☐ Normal	☐ Fast	☐ Slow	☐ Don't Know
Handedness	☐ Right	☐ Left	☐ Both	☐ Don't Know
Self-help Skills	☐ Average	☐ Fast	☐ Slow	☐ Don't know

Temperament (Infancy, Toddler, Preschool): Check any that apply

☐ Shy or timid	☐ Fearful	☐ Impulsive	☐ Rocking	☐ Stubborn	☐ Easy to manage
☐ Affectionate	☐ Cautious	☐ Poor sleep	☐ Temper	☐ Social	☐ Outbursts
☐ Curious	☐ Overactive	☐ Aggressive	☐ Happy	☐ Blank spells	☐ Underachiever
☐ Dare devil	☐ Curious	☐ Slow to warm up	☐ Poor eating		☐ Falling spells
☐ Wanted to be left alone		☐ More interested in things than people			
☐ Tore up toys more than usual					

Bowel Trained:	☐ Average	☐ Early	☐ Late	☐ Don't know
Bladder Trained:	☐ Average	☐ Early	☐ Late	☐ Don't know
Eating Behavior:	☐ Picky	☐ Eats too much	☐ Overeats sugar/carbohydrates	

Family Psychiatric History:

(Please note any that apply: Major Depression, Bipolar Disorder, Anxiety Disorders, Schizophrenia, Tic Disorders, Substance/Alcohol Abuse, Suicide Attempts, Eating Disorders, or other Psychiatric problems)

Have any of this child's **biological relatives** had psychiatric problems? ☐ Yes ☐ No ☐ Don't Know
If yes, please specify the problem next to the relative.

Mother _____
Father _____
Brother _____
Sister _____
Grandmother _____
Grandfather _____
Aunt _____
Uncle _____

Outside of biological relatives, are there any **other people with whom the child has significant contact** who have psychiatric problems?

If yes, please specify the contact(s) and describe the problem(s), including treatment: ☐ Yes ☐ No ☐ Don't Know

_____
_____
_____
_____
_____

Medical History of Child: Has this child had any of the following? Check any that apply

No	Yes	Don't know		Date(s)
☐	☐	☐	Measles	_____
☐	☐	☐	German Measles	_____
☐	☐	☐	Mumps	_____
☐	☐	☐	Chicken Pox	_____
☐	☐	☐	Whooping Cough	_____
☐	☐	☐	Diphtheria	_____
☐	☐	☐	Flu	_____
☐	☐	☐	Strep Throat	_____
☐	☐	☐	Meningitis	_____
☐	☐	☐	Encephalitis	_____
☐	☐	☐	Hay Fever	_____
☐	☐	☐	Abscessed Ears	_____
☐	☐	☐	Tubes in Ears	_____
☐	☐	☐	Allergy/Asthma	_____
☐	☐	☐	Convulsions	_____
☐	☐	☐	Head Injuries	_____
☐	☐	☐	Other Injuries	_____
☐	☐	☐	Other Illnesses	_____
☐	☐	☐	Problem with hearing	_____
☐	☐	☐	Problem with vision	_____
☐	☐	☐	Other	_____

Does this child currently take any medications for a medical illness? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____
_____
_____
_____

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_____	_____
Printed name of person completing form	**Date**
_____	_____
Signature of person completing form	**Date**
_____	_____
Signature of person completing form	**Date**