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Child's Name: _____ D.O.B.: _____ Age: _____

School: _____ Phone: _____ Teacher: _____ Grade: _____

How does your child do in school academically? _____

How does your child do in school behaviorally? _____

Does your child have a learning or physical disability? __Y, __N, __Maybe. Specify: _____

Does your child have a mental health diagnosis? __Y, __N, Specify:) _____

Does your family have any specific spiritual beliefs? _____

Medical History

During pregnancy, did mother use: __ Cigarettes, __ Alcohol, __ Drugs, __ Experience Extreme Stress?

Specify frequency, amounts, and duration: _____

List any birth complications (Ex: Premature, jaundice, C-section, etc.) _____

List any Medical conditions or history (Ex: Surgeries, broken bones, allergies, etc.) _____

Does child use: __ Cigarettes, __ Alcohol, __ Drugs

Specify amount and frequency: _____

Primary Care Physician: _____ Phone: _____ Last seen on: _____

Current medications: (Include dosage and frequency): _____

Medication Allergies: _____

Other Allergies: _____

In the first two years, did your child experience: ___ Separation from mother, ___ Out of home care,
___ Disruption in bonding, ___ Depression of mother, ___ Abuse, ___ Neglect, ___ Chronic pain, ___ Chronic Illness,
___ Parental Stress

If yes, please specify: _____

Reached developmental milestones: ___ On time, ___ Early, ___ Late

How many times has the child moved homes? _____

What are five adjectives that describe:

Mother: _____

Father: _____

Child: _____

Parental Relationship: _____

Family History

Biological Dad: _____ DOB: ___/___/___ Biological Mom: _____ DOB: ___/___/___
___/___/___ Married ___/___/___ Separated ___/___/___ Divorced

Siblings (1st to last): Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Custodial Adults (If not biological parents): Dad: _____ DOB: ___/___/___

Mom: _____ DOB: ___/___/___ Date became caretaker: ___/___/___

People in household, if different from above: _____

Does father work outside of the home? ___ Y, ___ N; Occupation: _____ Hours: _____

Father's highest level of education: _____

Does mother work outside of the home? ___ Y, ___ N; Occupation: _____ Hours: _____

Mother's highest level of education: _____

If separated or divorced, visitation schedule: _____

Does either parent have legal issues? _____

List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): _____

Have children witnessed domestic violence? ___ Y, ___ N, Specify: _____

How is your child disciplined? Please list each method and frequency of use: _____

Trauma History

Has your child been verbally abused? ___ Y, ___ N, ___ Suspected. Specify: _____

Has your child been physically abused? ___ Y, ___ N, ___ Suspected. Specify: _____

Has your child been sexually abused? ___ Y, ___ N, ___ Suspected. Specify: _____

Other stressors or traumas?

Circle the symptoms your child displays and list the number of times per week symptom is displayed:

- | | | | |
|--------------------|---------------------|---------------------|-------------------------------|
| Anger | Anxiety | Bed wetting | Acts out sexually |
| Conduct problems | Controlling | Day defecation | Has unusual sexual knowledge |
| Day wetting | Defiance | Depression | Homicidal thoughts or actions |
| Disassociates | Drug or alcohol use | Hyperactivity | Masturbates excessively |
| Hypervigilance | Impaired conscience | Isolation | Lack of empathy |
| Lack of motivation | Lethargy | Low impulse control | Plays out violent themes |
| Low self-esteem | Lying | Nightmares | Plays out sexual themes |
| Obsesses | Over/Under eating | Phobias | Peer problems |
| Phobias | Running Away | Shy | Sleeplessness |
| Stealing | Tantrums | | |

Somatic Symptoms: Headaches/Stomachaches, etc. _____

Other:

How does your child handle anger? _____

Has the child experienced any significant loss? If yes, explain: _____

What do you view as your child's major strengths and positive traits? _____

What are your child's hobbies? _____

Briefly describe your goals for your child's therapy: _____

Please list any information you deem to be important for the therapist to know: _____