Child History Form

Dr. Aaron Goldner, Psy.D. 248-894-4935

General Information

Today's Date _____

Child's Full Name_____
Date of Birth_____
Gender: Male / Female
Grade: _____
School name: _____
Home Address (include City, State, Zip code):
_____
_____

Mother's Name_____
Home number_____ **Work number**_____
Cell number:_____ **Employer:**_____

Father's Name_____
Home number_____ **Work number**_____
Cell number_____ **Employer**_____
Parent's marital status_____
Current custody arrangement (if applicable):_____
_____

Is this visit related to any type of legal or court proceeding? Y / N
If yes, please explain: _____

Are you the child's legal guardian? Y / N
If no, please list the following information for the guardian:
Guardian's Name:_____
Relation to child:_____ **Phone #:**_____

To reschedule appointments where may I call?
Home: Y / N
Work: Y / N
Cell: Y / N Text: Y / N
Please list any restrictions:_____
_____

Emergency Contact
Name:_____ **Relationship to child:**_____
Phone number:_____ **Alternate number:**_____

Overview

Reason for seeking treatment? _____
_____
_____

History of patient complaint (When did it first start, known cause or trigger? How often is client affected?): _____
_____
_____

Desired Goals/Outcomes. Please list below(include what concrete/objective signs will prove goal has been achieved):

1. _____
2. _____
3. _____

Mental Status

If suicidal or homicidal thoughts are present, is the person 1) *actively planning* to do harm or 2) just thinking about not wanting to be alive as a general wish to no longer feel pain?
Has your child ever made a suicide attempt/gesture? Y / N
If so, indicate the date and please explain _____
_____
_____

Has your child ever had a previous counseling/psychotherapy or had a neurological exam? Y / N
If yes, reason for treatment? _____
_____
What was the result? _____
_____

What are the child's usual Mood/Emotions? _____
How does child get along with others? _____
Memory: strong / poor
Judgment: good / poor
Speech/Thought Process: normal / problems
-if problems, please briefly describe: _____

Child's Insight into own problems: Strong/average/minimal
Impulse Control: Strong/average/minimal

Did your child achieve normal developmental milestones on time? (e.g. walking, talking)

Social

Friendships:

How does this child relate to other children? Well /poorly, Leader/Follower, isolated/bullied
Frequent fights with playmates? Y / N **Bullies or is Bullied? Y / N**
Prefers playing with younger children? Y / N **Prefers to relate to older children or adults? Y / N**
Has trouble making friends? Y / N
Prefers to play alone? Y / N
Are there children in the neighborhood with whom this child can play?

Medical History

Previous/Current Health Issues: _____
_____

Hospitalization History: _____
_____

Substance Use? Y / N
Smoking Cigarettes or using tobacco products? Y / N
Drug Use? Y / N if yes, what substances?
HIV risk? Y / N
Date of Last Physical Exam? _____

Motor Development and Functioning? Normal/Abnormal. If abnormal, please explain.
_____

Sensory Functioning? Normal/Abnormal. If abnormal, please explain.
_____

Immunization Status: Up to date / Unknown

Date of most recent physical exam: Reason for exam:
_____

Describe any major illnesses, injuries, or surgeries or hospitalizations:
_____
_____
_____

Is your child currently on any medications or a special diet (please list/describe):
_____
_____
_____

Has your child ever had a head injury? Y / N
Did he or she loose consciousness? Y / N
Has your child ever had a seizure? Y / N
Has your child ever sustained a high fever (above 101 degrees) Y / N
If yes, how high and when?_____

What allergies does your child have? (Please include any allergies to food, medications, pets, seasonal) _____
_____

Who in the child's home or life may have an alcohol or drug issue:
_____
_____

Is your child currently taking any psychotropic medication (e.g. ADHD medication, anti-depressants, anti-anxiety, etc.)? Y / N

Are there any speech, hearing, or learning difficulties? Y / N if yes, please explain: _____
_____

Has your child ever received speech/language services? Y / N
Has your child ever been evaluated for special education? Y / N
If yes, does your child have an IEP or a 504 Plan? (circle which one)
Date of most recent plan review: _____

Areas of Concern

Please circle areas of concern/distress:

Academic problems	**Y**	**N**
Aggressive Behavior	**Y**	**N**
Anxiety/Fear/Worries	**Y**	**N**
Attention/Concentration difficulties	**Y**	**N**
Bedwetting	**Y**	**N**

Behavior Problems	Y	N
Change in family dynamics (e.g divorce/remarriage)	Y	N
Depression	Y	N
Eating Problems	Y	N
Feelings over a recent loss/death	Y	N
Relationship with Family	Y	N
Relationship with Peers	Y	N
Relationship with Teachers	Y	N
Losing contact with reality	Y	N
Problems with Alcohol or Drugs	Y	N
Inappropriate Sexual Behaviors	Y	N
Social Situation Issues	Y	N
Problems Sleeping	Y	N
Potential harm to self/others, including statements or behaviors about suicide	Y	N

Please list any of your child's hobbies, sports, skills or talents:

_____

_____

Vision

Has your child ever had a comprehensive or behavioral vision exam? Y / N
Does your child wear glasses or contacts? Y / N
Does your child have any vision problems? Y / N
Date of last eye exam and Dr.'s name _____
Type of Doctor? E.g. optometrist, ophthalmologist, screening at school Y / N

Does your child frequently rub their eyes?	Y	N
Does your child complain of frequent headaches?	Y	N
Does your child complain of blurry or double vision?	Y	N
Does your child lose their place while reading?	Y	N
Does your child say that they dislike reading?	Y	N
Does your child frequently read entire passages but can't remember what was just read? (poor comprehension)	Y	N
Does your child seem to be light-sensitive?	Y	N
Does your child's eyes appear not to target at same point in space frequently?	Y	N
How long can your child read for before the any of the above symptoms appear? _____ Min		

Behavioral

Does/Is your child:

Have temper tantrums?	Y	N
Easily over stimulated in play?	Y	N
Have a short attention span?	Y	N
Lacks self-control?	Y	N
Seems unhappy a lot?	Y	N
Withholds affection?	Y	N
Hides feelings or fears?	Y	N
Seems overly energetic in play?	Y	N
Seems impulsive?	Y	N
Overreacts when faced with a problem?	Y	N

Other Problems

Speech problems? Y / N
Hearing problems? Y / N
Hypersensitive to: (circle any that apply) light / physical touch (e.g. being touched, tags in clothing, textures), others emotions

Abuse

Has this child ever reported being physically, sexually or verbally/emotionally abused? Y / N
***If yes, please discuss this with Dr. Goldner ***

Eating and Sleeping:

Does your child have any eating or appetite issues? Y / N
Are there any changes in your child's eating habits? Y / N
-When did you first notice this?_____
Is it an overeating or and under-eating issue? (please circle)

Are there any changes or issues in your child's sleeping habits?
(circle all that apply): Oversleeps, Sleepwalks, Has difficulty waking up in the morning, Wakes up during the night, Difficulty falling asleep, Has nightmares, Has Night Terrors

Gastrointestinal/Neurological/Cardiovascular Concerns:

Does you child have any of the following? (circle all that apply)
Shortness of Breath or dizziness with physical exertion, Frequent Diarrhea, Constipation, Stomach Pain, Sucks Thumb, Bites Nails, Grinds/Clenches Teeth, Accident Prone, Bangs Head, Rocks Back and Forth, Has Tics/Twitches, Verbal outbursts of inappropriate words or grunts/other noises, feinting.

Family

Please list any siblings (full/half/step): Name, Relationship, Age

_____
_____
_____

Family History

Is this child closer to one parent than the other? Y / N
If yes, which?_____

Has there ever been a divorce or separation or death? Y / N
If yes, when?_____ Age of child at the time?_____
Was Divorce Amicable? Y / N

If parents are divorced or separated, how often does the non-custodial parent see the child?
_____
How well does this child get along with his or her siblings?
_____
_____

Family Health

Has any family members had any of the following? If yes, please specify who and their relationship to the child. If child is not living with biological parents, please health information on biological parents, if known.
Tourette's Syndrome_____
Migraine Headaches _____

Behavior Disorder_____
Emotional Disturbance _____
Mental Illness _____
Nervousness _____
Seizures or Epilepsy _____
Reading Problems _____
Other Learning Disabilities _____
Speech or Language Problems _____
Food Allergies _____
Severe Head Injury _____
ADHD _____

Thank you for completing this comprehensive Child History Form.
The information you have given will aid in the therapeutic process.

Notes Area:
Please add any additional information you feel may be relevant to treatment: