Counseling Connections for Change, Inc.
Mental Health Matters!

Comprehensive Child History Form

Complete this form to the best of your knowledge. Write N/A for questions that do not apply to your child. If you wish to make additional comments and need more space, please attach an additional sheet of paper. The information included in this form is confidential. By providing accurate information and detail, your child's clinician will gain a better understanding of the presenting issues and will be better able to assist you.

Today's Date:________________ Name of Therapist:___________________________

General Information:

Child's legal name:_________________________________ Nickname:____________________

Date of birth: ____________________ Age: ___________ Grade: ____________________

Religion: ___________________ Race/Ethnicity: ____________________

Sexual Orientation:_________________________

Would you like your spiritual/religious beliefs incorporated into counseling?__No__Yes

Language(s) spoken in the home: ____

Address:____

City: ____________________ State: ____________________ Zip: ____________________

Home Phone: ____________________ Work Phone: ____________________

Cell: ____________________ Email Address(es): _______________________________________

Name of the person completing this form:____

Relationship to the patient:______________________

Is there an open CPS case?__Yes__No; Past?__Yes__No If there is an open or past CPS case please provide the case #_____________________

How were you referred to our office?____________________How will your services be paid?__Sliding scale (all cash clients complete this process)__Insurance (list the name)___________________________________

How would you classify your Employment Status:
__Wage Earner__Unemployed__Public Assistance__Retired__Student
__College Student__Homemaker__Social Security

What is the best way to contact you?_________________Is it okay to contact you at home?______________

Is the child adopted?__No__Yes; If yes, when?____
What are the details surrounding the adoption?____
Was the child in foster care?__No__Yes
Was it international?__No__Yes

Parent Name:____
Date of Birth: ____________________ Highest Grade Completed: ____________________
Occupation: ____________________ Employer: ____

Parent Name:____
Date of Birth: ____________________ Highest Grade Completed: ____________________
Occupation: ____________________ Employer: ____

Marital status of parents: Married Separated Divorced Widowed

Is a copy of the divorce decree with the custody information on file? __Yes__No__N/A

Additional Caregiver(s): Name:____

Relationship (nanny, grandparents, etc.):____

How much time does this person spend with your child?____

Who lives in the in the household with the child?

Name:	Age:	Male/Female (circle one)	Relationship to child:
		Male Female	
		Male Female	
		Male Female	
		Male Female	
		Male Female	

Child's Pediatrician or Family Doctor:
Name:____
Phone:_________________________________

Referral Information:
Who referred your child to us?
Name:____
Phone:_________________________________

Please list the names of other professionals consulted prior to coming to see us:

Name:	Profession:	When consulted:

Current Concerns:

Please circle to terms below that are areas of concern for your child.

Short attention span	Attention seeking	Distractibility
Impulsivity	Hyperactivity	Avoidance
Low frustration tolerance	Noncompliance	Skipping school
Oppositional behavior	Social isolation	Anxiety
Aggression	Lying	Stealing
Setting fires	Obsessive/compulsive behaviors	Cries easily
Touch/smell sensitivity; Light/sound sensitivity	Temper tantrums	Cruelty to animals
Weight loss or gain	Difficulty with transitions	Overly shy/clingy to parent
Lack of Remorse	Emotionally Disconnected	Low Self Esteem

Please explain circled boxes:

___

___

Do you have any other concerns?:___

When did you first notice these symptoms?___

Pre-natal History:

Please circle yes or no below.

Was this child part of a planned pregnancy?__Yes__No

Did either parent take medication or fertility drugs to become pregnant?__Yes__No

If yes, please list medication:___

Were there other medical procedures used to become pregnant with this child?__Yes__No

If yes, please explain:___

How many full term pregnancies has the mother had?___

Please list dates:___

Has the mother experienced any miscarriages, abortions, or stillbirths?__Yes__No

Please list dates:___

Were the parents married at the time this child was conceived? __Yes__No

Length of parents' marriage at the time the child was conceived:___

Are the parents currently together? __Yes__No

Circle for the following items which may have taken place during pregnancy:

Edema (swelling)	Toxemia	Accidents/Injuries
Vaginal bleeding	Breathing difficulties	Emotional stress
High blood pressure	Infections (cold, flu, urinary)	Pre-term labor
Fever	Hospitalization	Medication used:
Cigarettes used	Alcohol used	Illicit drugs used
Diabetes	Surgery	

Please explain all circled answers:____
____

Birth History:
Where was the child born? (city, state, country)________________________________
Was the child born on-time?__Yes__No
If no, was he/she early or late? By how many weeks?_____________________________
Weight of child at birth:_________________ Age of mother at birth:___________________
Apgar scores (if known):_________________ Age of father at birth:___________________

Does either parent have children from a previous relationship?__Yes__No
If yes, please list the names and ages of children and parent below:
____
____

Please circle all that apply below for this child's birth:

Spontaneous labor	Vaginal delivery
Induced labor	Breech presentation
Toxemia with Eclampsia	VBAC (vaginal birth after c-section)
Fetal distress	C-section (planned? Yes No)
Maternal fever	Medication used

Please add any comment regarding the items noted above:__________________________
____

Post-delivery Period:
How many days did the baby stay in the hospital after birth?_______________
How many days did the mother stay in the hospital after delivery?___________________

Circle the items which may have occurred during the days following the child's birth:

Difficulty breathing	Infection	Need for ventilation	Jaundice
Blood transfusion	Poor feeding	Vomiting/reflux	Water on the brain
Floppy muscle tone	Turned blue	Neonatal ICU (NICU)	Fever

Please explain all circled items:____
____

Development:
Was your child breastfed?__Yes__No
If yes, from__________ until age________
Describe the circumstances for terminating breastfeeding:__________________________
____

Describe the weaning process:____
Was your child bottle fed?__Yes__No
If yes, from__________ until age________

Describe the circumstances for terminating bottle feeding:____

____

Did your child have colic?__Yes__No
If yes, for how long?__________________
Did your child have any feeding problems?__Yes__No
If yes, please describe:____

Circle items below which may have occurred during the first few years of life:

Difficult to comfort	Sleep difficulties
Excessive irritability	Excessive restlessness
Extremely passive	Frequent head banging
Always had to be held	Other

Please explain any circled answers:____

____

Please complete the chart below regarding your child's accomplishment of early developmental milestones:

Milestone	**Age accomplished**	**Did you feel this was:**
Smiled (social smile)		On time Early Late
Laughed		On time Early Late
Sat independently		On time Early Late
Crawled independently		On time Early Late
Stood independently		On time Early Late
Walked independently		On time Early Late
Waved bye-bye		On time Early Late
Toilet trained (urine)		On time Early Late
Toilet trained (bowel)		On time Early Late
Spoke first words		On time Early Late
Put two words together		On time Early Late

What were your child's first words?____
Could you understand your child's speech by age 2 years?__Yes__No
Could <u>others</u> understand your child's speech by age 2 years?__Yes__No
Could your child speak simple sentences by age 2 years?__Yes__No

How does your child typically communicate now? Circle below.

Gesture	Words	Sentences

What are the sleeping arrangements? Circle below.

Room alone	With sibling	Parents room	Other

Where does your child sleep? Circle below.

Crib	Bed	Parents bed	Other

Is it difficult for your child to go to sleep?__Yes__No
How long does it take him/her to fall asleep?________________
Do you have a regular bedtime?__Yes__No Describe:____________________________________
Does your child wake up during the night?__Yes__No If yes, how many times?_____________________
How long does he/she stay awake?_____________
What helps him/her go back to sleep?____
Is your child a restless sleeper? Yes No
Does (Did) your child have a special object (blanket, teddy bear, etc.)? Yes No
If yes, describe:____ Until what age?__________

How many hours of screen time (TV, video games, etc.) does your child have each day?___________________
What are his/her favorites?____

Temperament:
We would like to have an understanding of your perception of your child's temperament. Please describe her/his temperament below:

____

Circle the type of discipline you use with your child:

Rewards	Verbal reprimands
Time out	Removal of privileges
Avoidance of child	Physical punishment
Time in's	Other

Which form of discipline has proven most effective?____

How often must you discipline your child?____

Does your child have any close friends? Yes No (how many?___________)

Please circle below.

How does your child get along with peers?	Well	Average	Poor
How well does your child make new friends	Well	Average	Poor
Does your child get along best with children:	Older	Same Age	Younger

Please circle if your child is:

Loud and noisy	Easily angered	Able to entertain him/herself
Sensitive to sound	Shy with new adults	Affectionate
Sensitive to touch	Shy with new children	Aggressive
Sensitive to light	Physically cautious	Clingy
Sensitive to smell	A dangerous risk taker	Overly active

Please explain all circled boxes:____
____

What are your child's favorite activities?____
____

What are your child's least favorite activities?____
____

Describe your child's typical mood?____

What about your child are you most proud of?____

Child's Health History:

Circle items below which your child may have experienced:

Vision problems	Hearing problems	Asthma	Allergies	Stomach aches
Sleep problems	Bed-wetting	Stool soiling	Chronic ear infections	Hospitalization
Surgery	Head trauma	Loss of consciousness	Coma	Seizures
Tics	Staring spells	Tremor	Frequent falls	Anemia
Broken bones	Stitches	Accidental poisoning	Floppy muscle tone	Nutrition problems
Pica (eating non-food items)	Persistent high fever	Excessive vomiting	Headaches	Other problems

Please explain all circled answers:____
____

Do you have any particular concerns regarding your child's physical health? Yes No
If yes, please explain:____
Does your child have any current mental health diagnoses?__No__Yes,
List________________________________

Does your child currently take medication? No Yes,
list____
List any medications taken in the past:____
When was your child's last medical exam?________________________ Where:_________________________

Please circle if your child has had any of the following:

Individual psychotherapy	Group psychotherapy	Occupational therapy
Physical therapy	Speech therapy	Developmental evaluation
Educational evaluation	Brain scan (CT or MRI)	EEG testing
Genetic/Chromosome tests	Lead testing	Other (explain below)

Please explain all circle boxes including dates, providers, and results:_______________________________________

____

Family Health History:

Please mark yes or no for each item below that may apply to a family member and then state relation (e.g., mother, brother, maternal uncle, maternal niece, etc.)

Yes	No		Relation to the child:
		Heart disease	
		Cancer	
		Vision problems	
		Hearing problems	
		Epilepsy/seizures	
		Birth defects	
		Cerebral palsy	
		Genetic condition	
		Muscle/motor problem	
		Other (explain below)	

Explanation:____

Are there any other health issues that run in the family? Yes No

Explain:____

Family Emotional and Learning History:

Mark yes/no for each item below that may apply to a family member and then state relation (e.g., mother, brother, maternal uncle, maternal niece, etc.)

Yes	No		Relation to child:
		Depression	
		Substance Abuse	
		Alcoholism	
		Hyperactivity/ADHD	
		Oversensitive to Sound/Touch/Taste/Smell	
		Learning problems	
		Autism Spectrum Disorder	
		Speech problems/delays	
		Eating problems (anorexia, bulimia)	
		Post-partum depression	
		Intellectual disability (formerly Mental Retardation)	
		Phobias/fears	

		Down Syndrome	
		Anxiety	
		Schizophrenia	
		Obsessive Compulsive Disorder	
		Bipolar Disorder (Manic Depression)	
		History of Domestic Violence	
		History of Sexual Assault	
		History of Suicidality	
		History of Self-harm (cutting)	
		Other (describe:)	

Please add any relevant details you feel are important regarding the items above:___________________________

____

Has any blood relative to your child experienced problems similar to those your child is currently experiencing?
No Yes,
explain:____

<u>Recent and Past Stressful Events and Support</u>:

Please circle if <u>either parent</u> has experienced any of the following:

Major accident/illness	Moving homes	Loss of significant other
Financial setback	Loss of family member/friend	Difficulty as a couple
Separation from child	Therapy/counseling	Recent or Past Trauma
Incarceration	Arrests or pending charges	Past or current experience with using illegal substances

Please explain all circled boxes (What happened? When? What support did you have? How did you deal with the event?:____

____

Please circle if <u>your child</u> has experienced any of the following:

Separation from parent	Moving homes	Addition of new sibling
Major accident/illness	Loss of family member/friend	Other (explain below)
Recent or Past Trauma	Juvenile history of arrests or pending charges	Past or current experience with using illegal substances

Explain all circled boxes (What happened? When? What support did you have? How did you deal with the event?:____

____

Are there weapons in the home?__No__Yes; does your child have access?__No__Yes

Do you feel that your child is a risk to self or others?__No__Yes;
Explain:____

____

School/Education History:

Does your child attend school/preschool/daycare? Yes No

Name of your child's current school/preschool/daycare:_______________________________________

Address:____

Telephone:_________________________ Teacher:____________________

Grade:____________

Director:_________________________________

Special placement (if any):___________________

Please list the following information for each school/daycare your child has attended:

Name	Age	Beginning date	End date	Hours per day & days per week

Please circle all that apply to your child's preschool/daycare/or school experience:

Adjustment problems	Bullying	Services through ECI
Services through PPCD	Services at school (speech, OT)	Extra support in classroom
Pullouts (reading, math)	School completed testing	IEP or ARD
Retained a grade	Asked to leave school/program	Suspended from school
Expelled from school	Performance below peer level	Other (explain below)

Please explain all checked boxes:____

____

____

What do you see as your family strengths?:____

____

____

____

Please list at least one goal you would like to reach during the course of therapy.

____

____

____

____

____