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| **Logo, company name  Description automatically generated** | *1940 Harrison Street suite 306 Hollywood FL 33020 | 516-418-2673***Child Health History Form** |

# CHILD HEALTH HISTORY FORM

Today’s date:

Child’s name: Age: Date of birth:

Name of person completing this form:

Relationship to child: (Mother?) (Father?) (Other?)

Name of pediatrician:

Pediatrician’s Phone number: Fax:

Who is requesting or recommending these services for your child? (circle all that apply)

### Parent Therapist Physician Pediatrician Psychiatrist School

**Attorney DFCS Court Other**?

What is the reason for the visit today?

What are your primary concerns about your child?

**CHECK THE FOLLOWING THAT APPLY**:

 Depression Anxiety

 Mood swings Low motivation

 Suicidal ideation Hallucinations

 Hyperactivity Difficulty focusing

 Aggression Anger

 Defiance Lying

 Temper tantrums Sexual acting out

 Developmental delays Language delay

 Poor social skills Poor eye contact

 Sensory concerns Poor memory

 Self-harming behavior

 Low self-esteem

 Bizarre or strange behavior

 Difficulty concentrating

 Stealing

 Hoarding food

 Attention-seeking

 Learning problems

 Bed wetting

 Organization problems

 Eating disorder symptoms Low frustration tolerance

 Motor skills or coordination problems

# DEVELOPMENTAL HISTORY

Length of pregnancy: Child’s weight at birth:

Any problems with pregnancy or delivery? (circle one) **YES NO DON’T KNOW**

If yes, please explain:

Any known alcohol or substance abuse during pregnancy? **YES NO DON’T KNOW**

If yes, please describe: \_

Any health problems at birth? **YES NO**

If yes, describe:

Was infant hospitalized for any length of time after birth? **YES NO**

If yes, briefly describe:

Any delays with developmental milestones (talking, walking, potty training, etc.)?

**YES NO** If yes, please explain:

Has your child ever received any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Currently? | In the Past? | If yes, describe: |
| **Speech Therapy** |  |  |  |
| **Physical Therapy** |  |  |  |
| **Occupational Therapy** |  |  |  |

## MEDICAL HISTORY

When was your child’s last visit to the pediatrician? Any concerns at that time? **YES NO**

If yes, please explain:

Does your child have hearing or vision problems? **YES NO**

If yes, are they corrected (with glasses, contact lenses, hearing aids, etc.)? \_

Has your child ever been hospitalized for general medical reasons? **YES NO DON’T KNOW**

If yes, reason and approximate date(s):

Has your child ever had surgery? **YES NO DON’T KNOW**

If yes, briefly describe:

Does your child have any chronic illness (such as diabetes, asthma, etc.)? **YES NO**

If yes, briefly describe:

Does your child have any medication, food, or other allergies? **YES NO DON’T KNOW**

If yes, briefly describe:

Does your child ***currently*** take any prescription medications (non-psychiatric)? **YES NO**

If yes, medication names:

Has your child ever had any head injuries? **YES NO DON’T KNOW**

If yes, briefly describe:

Has your child ever had any other major injuries? **YES NO DON’T KNOW**

If yes, briefly describe:

Does your child have any appetite problems or problematic weight gain or weight loss?

### YES NO DON’T KNOW

If yes, briefly describe:

Does your child have any sleep problems or nightmares? **YES NO**

If yes, briefly describe:

## FAMILY HISTORY

Names & ages of child’s siblings:

Who currently lives in the home?

**Check any family crises or problems that have occurred in child’s household:**

(describe further in the comments section below as needed)

 Separation/divorce of parents

 Death of a family member

 Death of a pet

 Serious illness of a family member

 Parent’s new job

 Move to a new home

 Birth of sibling

 Addiction of family member

 Other

Comments:

Does your child have opportunities to play with other children?

How does you child get along with other children?

What are your child’s favorite activities?

## EDUCATIONAL HISTORY

Name of child’s school:

What grade is he/she in? Current or most recent grades:

Has your child repeated any grades? (if yes, which ones?)

Is your child receiving special education services? **YES NO**

If yes, for what reason? (circle all that apply) **behavioral emotional educational**

Any major school discipline (suspensions, expulsions) or behavior problems in school? **YES NO**

If yes, briefly describe:

# MENTAL HEALTH HISTORY

Has your child ever received a mental health diagnosis in the past? **YES NO**

If yes, what diagnosis? \_

Has your child ever seen a psychiatrist for psychiatric medication? **YES NO**

If yes: Name of psychiatrist ? When?

Is your child ***CURRENTLY*** taking psychiatric medications? **YES NO**

If yes, name(s) of medication(s):

Has your child taken any other psychiatric medication in the past? **YES NO DON’T KNOW**

If yes, names of medications and dosages (if known):

Has your child ever had a psychological evaluation? **YES NO DON’T KNOW**

If yes, when and what was the diagnosis?

Is your child ***CURRENTLY*** receiving therapy or counselling for emotional or behavioral problems?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *(circle all that apply)* | Provider or Agency | Date Started | Frequency | For what issues? |
| **Individual** |  |  |  |  |
| **Group** |  |  |  |  |
| **Family** |  |  |  |  |
| **Other** |  |  |  |  |

Has your child received therapy or counseling in the ***PAST*** for emotional or behavioral problems?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *(circle all that apply)* | Provider or Agency | Date Started | Date Stopped | Why did the therapy stop? |
| **Individual** |  |  |  |  |
| **Group** |  |  |  |  |
| **Family** |  |  |  |  |
| **Other** |  |  |  |  |

Has your child ever been admitted to a psychiatric hospital? **YES NO**

If yes, please list date(s) and name(s) of hospitals:

Has your child ever had suicidal thoughts or made suicidal threats? **YES NO DON’T KNOW**

If yes, briefly describe:

Has your child made any suicide attempts? **YES NO DON’T KNOW**

If yes, briefly describe:

Has your child ever been abused or neglected? **YES NO DON’T KNOW**

If yes, circle those that apply and briefly describe:

|  |  |
| --- | --- |
| *(circle all that apply)* | Briefly describe |
| **Physical** |  |
| **Verbal / Emotional** |  |
| **Sexual** |  |
| **Neglect** |  |

Is there any history of mental health problems in the child’s family?

### YES NO DON’T KNOW

If yes, briefly describe:

How do you typically discipline your child?

Are there any additional concerns about your child?