CHILD PERSONAL HISTORY QUESTIONNAIRE

1. REGARDING THE CHILD

Form Completed By: _____ Date: ____/____/____

Child's Name: _____ Age: ____ Birth Date: ____/____/____

Sex: _____ M _____ F Home Phone: _____

Address: _____
City State Zip Code

School: _____ Grade: _____ Teacher: _____

Other School personnel who have had contact with the child regarding these problems:

_____

How did you hear about our clinic? _____

Child's Physician: _____
Name Address Phone

Previous Counseling or Mental Health Services:

Name: _____ Dates: _____

Name: _____ Dates: _____

Name: _____ Dates: _____

What are some examples of your child's behavior which are concerned about?

_____
_____
_____
_____
_____
_____
_____
_____

CLINICIAN USE ONLY
Do Not Write Below

Client's Name: _____ **Date of Birth**: _____/_____/_____

Check any behaviors that apply to your child:

____ cries easily	____ easily frustrated	____ happy/cheerful
____ impulsive	____ stick-to-it-ness	____ sad
____ stubborn	____ poor self-control	____ lot of courage
____ shy	____ foolhardy/thoughtless	____ rebellious
____ submissive	____ defiant	____ good judgment
____ show-off	____ leader	____ responsible
____ sensitive	____ follower	____ tells lies/fibs
____ slow to anger	____ fights easily	____ steaks
____ talks to self	____ tantrums	____ honest
____ fantasy life	____ moody	____ mean to animals
____ short attention span	____ distractible	____ peculiar behavior
____ aggressive	____ bad memory	____ destructive
____ fidgety	____ withdrawn	____ lights fires
____ clinging	____ fearful	____ suicidal thoughts
		____ suicidal attempts

____ other (please describe) _____

_____

_____

When did these problems begin? _____

_____

_____

How would you like things to be different? _____

_____

_____

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Client's Name: _____ **Date of Birth**: _____/_____/_____

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2. MEDICAL HISTORY/HOSPITALIZATIONS

Serious illnesses: _____

Serious injuries: _____

High fevers: _____

Hospitalizations: _____

Please check if your child has experienced any of the following:

____ dental problems	____ sleep problems	____ accidents/broken bones
____ skin problems	____ tiredness/fatigue	____ poor appetite
____ hair/scalp problems	____ nightmares	____ weight loss
____ allergies/hay fever	____ sleepwalking	____ obesity
____ asthma	____ talking in sleep	____ stomach problems
____ pneumonia	____ bed wetting	____ phobias
____ ear infections	____ urinary infections	____ tics
____ hearing problems	____ constipation	____ thumb sucking
____ vision problems	____ diarrhea	____ nail biting
____ severe headaches	____ hemorrids	____ menstrual problems
____ dizziness/fainting	____ soils underwear	____ sexual difficulties
____ seizures/epilepsy	____ high blood pressure	____ venereal disease

____ other-specify _____

Is the child presently under a physician's care for any of the above? ____ Yes ____ No

If yes, name of physician: _____

Is the child presently on any medications? ____ Yes ____ No

If yes, please list name and dosage: _____

_____

Date of child's last physical examination: _____

Client's Name: _____ **Date of Birth**: _____/_____/_____

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Is there any history of emotional problems, depression, alcoholism, or suicide in your immediate family? ____ Yes ____ No If yes, who and when:

_____

Has your child been in any difficulty with the law? ____ Yes ____ No

If yes, please describe: _____

_____

_____

Approximately how many close friends does your child have? _____

Are most of your child's friends: ____ older ____ younger ____ same age as your child?

3. DEVELOPMENT

Was the pregnancy planned? ____ Yes ____ No

How did you feel about the pregnancy? _____

_____

_____

Were there any problems at the time of the pregnancy? _____

_____

Was the delivery difficult? ____ Yes ____ No If yes, please describe: _____

_____

_____

At approximately what age did your child do the following:

Walk alone _____ Complete toilet training_____

Speak single words _____ Stop wetting the bed _____

Speak phrases _____ Dress him/herself _____

Client's Name: _____ **Date of Birth**: _____/_____/_____

4. REGARDING THE FAMILY

CLINICIAN USE ONLY
Do Not Write Below

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

Occupation:_____ Work Phone:(____)_____

Marital Status:_____M _____D _____Separated _____ Single Birth Date:_____

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

Occupation:_____ Work Phone: (____)_____

Marital Status:_____M _____D _____Separated _____Single Birth Date:_____

Brothers and Sisters of Patient:

Brothers:		Sisters:	
_____	DOB:_____	_____	DOB:_____
_____	DOB:_____	_____	DOB:_____
_____	DOB:_____	_____	DOB:_____
_____	DOB:_____	_____	DOB:_____

Who lives in the home now? _____

_____

If parents are divorced, when did this occur?_____

How long were you married prior to the divorce?_____

Were there previous marriages? _____ Yes _____No

Frequency of non-custodial parent's contact with the child: _____

_____

_____

Have any of your other children had behavior or learning problems? ___Yes ___No

If yes, please describe: _____

_____

_____