Person Completing Form ____________________ Relationship to Child ____________________ Date_____

Child's Name____________________ Birthdate____________________ Age____________________

Home Address____
(Street) (City/Town) (State) (Zipcode)

Home Telephone________________ Child's School____________________ Grade__________

Special School Placement or Services(if any)____

Adults living with Child____
(name and relationship)

Siblings (name and age)____

PARENTS

Father____________________ Occupation____________________ Work Telephone__________

Mother____________________ Occupation____________________ Work Telephone__________

Pregnancy Complications

Vomiting____ Staining or blood loss______ Infections____ Toxemia____ Threatened Miscarriage___
Other Illness____
Smoking During Pregnancy____Number of cigarettes per day ________ Drug or alcohol use__________
Duration of Pregnancy (weeks)______________Other Complications____________________________

DELIVERY

Type of labor: Spontaneous____ Induced____ Duration (hours) ____ Birth Weight _______
Type of Delivery: Normal ____ Breech ____ Cesarean ____
Complications: Cord around neck ____ Hemorrhage__ Infant Injury ____

POST DELIVERY: Jaundice ____ Cyanosis (blue baby) ____ Incubator Care____ Infection _______ (specify)

INFANCY:

Difficult to calm or comfort _______ Colicky _____ Excessively irritable_____ Head Banging_____
Difficulty nursing____ Disturbed sleep patterns (describe)____________________________
Other:____

MEDICAL HISTORY:

Childhood Diseases (describe ages and complications)____________________________

____

Hospitalizations____
Head Injury_____ Coma_______ Convulsions with fever ______ without fever______________
Eye problems (specify)____________________ Ear problems (specify) ____________________
Allergies (specify)____ Asthma __________
Eating Problems____
Sleep Disorders____
Other Problems____

MENTAL HEALTH HISTORY

Describe any past history of severe social, emotional or behavioral problems____________________

____

____

____

Patient Name:______________________________ Date:______________________

Describe any significant history of physical or emotional trauma____________________
____
____
____
____

List previously seen mental health providers and addresses if available______________
____
____
____

PRESENT MEDICAL STATUS

Present illnesses for which the child is being treated______________________
Prescription Medications______________________
Name of Primary Care or other treating physicians______________________
Date of last medical checkup ______________________

DEVELOPMENTAL MILESTONES

If you can recall, record the age at which your child reached the following developmental milestones. If you do not recall the age, check the categories to the right.

	AGE	EARLY	NORMAL	LATE
Sat without support				
Crawled				
Walked without assistance				
Spoke first words				
Said sentences				
Toilet Trained				

FAMILY HISTORY

For each of the following, please specify which relative (parents, siblings, grandparents, aunts, uncles or cousins) and which side of the family (maternal or paternal) has or had a history of the problem or disorder.

Reading Disorder______________________
Math Disorder______________________
Speech Impairment______________________
Mental Retardation______________________
Epilepsy______________________
Tic Disorder______________________
Tourette's Syndrome______________________
Behavior Problems______________________ (Childhood)

Thyroid Disorder______________________
Genetic Disorder______________________ (Specify)
Depression______________________
Bipolar Disorder______________________
Obsessive-Compulsice Disorder______________________
Social Phobia______________________
Panic Disorder______________________
Attention/Hyperactivity Disorder______________________

SCHOOL EXPERIENCE

Rate your child with regard to academic performance

GRADE	GOOD	AVERAGE	POOR
Kindergarten			
Earlier Grades			
Current Grade			

What is your child's grade level in: Reading_____ Spelling_____ Math_____
Has your child ever had to repeat a grade?___________ If so, what grade______________________
Has your child ever been evaluated for Special Education?___________ If so, for what reason_________

Patient Name:______________________ Date:______________________

BEHAVIOR CHECKLIST

Please check all of the following that apply to your child:

Is moody	Has a bad temper	Cries easily
Is a worrier	Has bad dreams	Is often sad
Is often quiet	Is fearful of new situations	Is fearful of being alone
Is often tired	Stutters or stammers	Frequent stomach aches
Frequent headaches	Wets bed or pants often	Soils or has bowel accidents
Frequent diarrhea	Frequent constipation	Overeats
Bites nails	Is slow to trust	Demands to be the center of attention
Fights with siblings	Excessively neat or orderly	Too concerned about germs or cleanliness
Tells lies	Steals	Plays with fire
Bullies other children	Is fresh or rude to adults	Is mean
Destroys own property	Destroys others property	Deliberately provokes adults
Frequently in trouble with neighbors	Is cruel to animals	Is a loner
Has no real friends	Has mostly younger friends	Has mostly older friends
Is bossed by other children	Prefers to play alone	Gets picked on
Is not liked by other children	Difficulty sustaining attention	Makes careless mistakes
Often does not seem to listen	Fails to finish things	Difficulty organizing activities
Avoids sustained mental effort	Often loses things	Easily distracted
Forgetful in daily activities	Often fidgets	Often out of his/her seat in the classroom
Is hyperactive	Difficulty playing quietly	Talks excessively
Blurts out answers before questions are completed	Difficulty waiting turn	Often interrupts or intrudes
IF YOUR CHILD IS 12 YEARS OR OLDER		
Is sexually active	Appears confused about gender	Displays interest in the same sex
Behavior is rigid and repetitive	Is troubled by obsessive thoughts	Has many health complaints
Experiences times of extreme fear or panic	Uses alcohol	Uses illegal drugs
Inhales household chemicals		

Additional Remarks: (use other side of paper if more space is required)