

EMOTIONAL/PSYCHIATRIC HISTORY

Has your child been in counseling before? _____ No _____ Yes:

Name of Counselor	Counselor Address	Counselor Phone No.	Dates of service	How many sessions?

Has your child ever been hospitalized for a psychiatric or substance use disorder? _____ No _____ Yes:

Name of facility	City and state of facility	Facility phone number	Admission date	For how long?

Does your child take any medication(s)? _____ No _____ Yes If yes, what medication(s) and for which condition(s)? _____

Has any family member used psychiatric medication(s)? _____ No _____ Yes If yes, who/what/why (list all): which condition(s)?

Does your child have a history of physical or sexual abuse, neglect, witnessing domestic violence, trauma, prolonged separation, or abandonment? _____ No _____ Yes, If yes, please provide details of experience (including type, age of onset, duration, and any apparent trauma effects):

Emotional health problems of family: (check all that apply)

	Mother	Father	Sister	Brother	Aunt	Uncle	Grandparents
Alcohol/drugs							
Anxiety							
Attention Deficit							
Bipolar Disorder							
Depression							
Eating Disorder							
Posttraumatic stress							
Schizophrenia							
Suicide attempt							

Family Relationships:

List other adults and children living in the home:

Name	Age	Gender	Relationship to Child	Quality of Relationship?
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
_____	_____	_____	_____	Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>

Child's Development:

Please indicate if any of the following occurred during the pregnancy and developmental period for your child:

Medical problems during mother's pregnancy?	_____ No	_____ Yes	If yes, please describe: _____ _____ _____ _____ _____ _____
Poor/inadequate prenatal care?	_____ No	_____ Yes	
Mother used drugs/alcohol/cigarettes during pregnancy?	_____ No	_____ Yes	
Mother experienced unusual stress during pregnancy?	_____ No	_____ Yes	
Labor or delivery problems?	_____ No	_____ Yes	
Child had problems during the newborn period?	_____ No	_____ Yes	
Developmental delays (walking, talking, toilet training, etc.)?	_____ No	_____ Yes	
Poor temperament in early childhood?	_____ No	_____ Yes	_____

Medical history

Describe current health: [] Good [] Fair [] Poor

Name of personal physician: _____

Address: _____ Phone number: _____

Name of psychiatrist (if any) : _____

Address: _____ Phone number: _____

Date of last physical exam: _____

List any abnormal test results: _____

Describe any serious hospitalizations or accidents:

Date _____ Age _____ Reason _____

Date _____ Age _____ Reason _____

Date _____ Age _____ Reason _____

School History:

Child's school _____ Grade _____

Does/has your child...

If yes, please describe:

have learning problems?	_____ No	_____ Yes	_____
have behavior problems in school?	_____ No	_____ Yes	_____
have social problems in school?	_____ No	_____ Yes	_____
receive special help in school?	_____ No	_____ Yes	_____
ever been held back a grade?	_____ No	_____ Yes	_____
have other school problems?	_____ No	_____ Yes	_____

Is it ok to contact school staff about child? _____ No _____ Yes: Teacher/Staff _____

School Address _____ Phone _____
Street City State Zip Code

Please write down anything else you think we should know:
