

CHILDHOOD HISTORY FORM

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Associates
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Child's Name: _____

Child's Home Address: _____

_____ Sex: _____ Birth Date: _____ Age: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Child's School: _____ Grade: _____

Special Placement (if any): _____ Bilingual? Yes No

Primary language in the home: _____ Ethnic Background: _____

Child is presently living with: Birth Mother Birth Father Stepmother Stepfather

Adoptive Mother Adoptive Father Other (Specify): _____

Who else regularly provides care for your child? _____

Does your child have regular visitation with a non-custodial parent? Yes No If so, what is the schedule? _____

Source of Referral: _____

Who is your family doctor or physician? _____

When was your child's last physical examination? _____

Current physical problems or symptoms: _____

Is your child taking any medications? Yes No If so, Please list them: _____

Past medications: _____

Has your child had any serious illnesses, accidents, operations or been hospitalized? _____

Please list your main concerns in order of importance: _____

Please list any specific questions you would like answered:

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Please list your child's main hobbies, interests, strengths and community activities: _____

Hours your child spends with the following each day? _____TV _____ Xbox/Wii/Video Gaming _____Internet

FAMILY AND SOCIAL HISTORY

FATHER: Name: _____ Age: _____

Address: _____

_____ Phone: _____

Highest Grade Completed: _____ Occupation: _____

Describe quality of relationship: _____

MOTHER: Name: _____ Age: _____

Address: _____

_____ Phone: _____

Highest Grade Completed: _____ Occupation: _____

Describe quality of relationship: _____

SIBLINGS/OTHER HOUSEHOLD MEMBERS: Names: _____

Ages: _____ General Health: _____

Describe quality of relationship: _____

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Ages: _____ General Health: _____

Describe quality of relationship: _____

FAMILY HISTORY	CHILD'S MOTHER	CHILD'S FATHER	CHILD'S BROTHER(S)	CHILD'S SISTER(S)	OTHERS <input type="text"/>
Concentration/Attention Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior Problems in Childhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinking Problems or Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tics/Nervous Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any significant stressors, such as moving, illness, divorce, losses, separation from parents, or domestic violence: _____

Has child ever experienced: Sexual Abuse Physical Abuse Emotional Abuse Neglect

Have you suspected or ever worried about your child being harmed in any other way? _____

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Describe the types of discipline that you have used with your child and how effective they have been: _____

Have you participated in a parenting class or obtained other forms of information concerning discipline and behavior management? _____

PEER RELATIONSHIPS

Does your child have problems making/keeping friends? _____

Does your child play with other children the same age? _____

Younger? _____ Older? _____

Briefly describe any problems your child may have with peers. _____

How does your child get along with other family members? _____

MEDICAL AND DEVELOPMENTAL HISTORY

PREGNANCY

While you were pregnant with this child, were you under a doctor's care? Yes No

Describe any medical, emotional or substance use issues during pregnancy (please include any medications used during pregnancy). _____

BIRTH HISTORY Mother's age at time of birth: _____ Father's age at time of birth: _____

Did mother smoke during pregnancy? Yes No

Drink Alcohol? Yes No

What did the baby weigh?: _____

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How many hours from first contractions to birth?: _____

Were you given medication or anesthesia?: Yes No

If yes, please describe: _____

Was the delivery unusual in any way? Yes No If yes, please describe: _____

Did you have a Cesarean? Yes No If yes, any complications?: _____

Did this baby have: breathing problems? Yes No Cord around neck? Yes No

Was this baby's color normal? Yes No Blue Yellow Don't Know

Was oxygen used for this baby? Yes No Don't Know How Long? _____

Was the baby premature or late? Yes No How much? _____

Did you take the baby home with you from the hospital? Yes No How long after delivery? _____

Please describe any problems this baby had during the first few months of life (e.g. feeding, colic, activity):

MEDICAL HISTORY OF CHILD:

Check all that apply	Age
<input type="checkbox"/> Measles	
<input type="checkbox"/> Chicken Pox	
<input type="checkbox"/> Flu	
<input type="checkbox"/> Diphtheria	
<input type="checkbox"/> Ear Infection	
<input type="checkbox"/> Head Injuries	
<input type="checkbox"/> Sleep Problems	
<input type="checkbox"/> Soiling	
<input type="checkbox"/> Headaches	

Has your child had any of the following?

Check all that apply	Age
<input type="checkbox"/> German measles	
<input type="checkbox"/> Whooping Cough	
<input type="checkbox"/> Strep Throat	
<input type="checkbox"/> High Fever	
<input type="checkbox"/> Tubes in Ears	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Other _____	

Check all that apply	Age
<input type="checkbox"/> Mumps	
<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Meningitis	
<input type="checkbox"/> Encephalitis	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Vision Problems	
<input type="checkbox"/> Wetting	
<input type="checkbox"/> Other Injuries	
<input type="checkbox"/> Other _____	

Is your child involved with street drugs or alcohol? Yes No

If yes, please describe: _____

Age of menstruation (if applicable): _____ Problems? Yes No



Has this child been sexually active? Yes No If yes,

please describe: _____

DEVELOPMENTAL HISTORY: (Answer as best you can remember)

- Motor Development (Sitting, Crawling, Walking): Early Normal Delayed
- Speech & Language: Early Normal Delayed
- Self-help Skills (Dressing, Brushing, Shoe tying): Early Normal Delayed
- Toilet Training: Early Normal Delayed
- Handedness: Left Right Both
- Eating Behavior Overeats sugar/carbs Eats too much Picky

SENSORY CONCERNS: Is your child sensitive to, or do they display, any of the following?:

- Light Touch Rocking
- Head banging Sounds Textures
- Falling Spells Sock seams/tags Food textures/aversions

TEMPERAMENT (Infancy, Toddler, Preschool): Check any that apply.

- Shy or Timid Fearful Impulsive Stubborn
- Easy to Manage Aggressive Affectionate Social
- Easy-going Outgoing Underactive Slow to warm-up
- Curious Into Everything Overactive Temper Outbursts
- Destructive Happy Daredevil Wanting to be left alone
- More interest in things than people Other(s) _____

SCHOOL HISTORY

Do you believe your child understands directions and interprets situations as well as other children his or her age? _____

If not, please describe: _____

How would you rate your child's overall level of intelligence compared to other children? Below Average

Average Above Average Additional Comments: _____

Please list previous psychological/academic evaluations (please provide copies): _____

To the best of your knowledge, at what grade level is your child functioning?			
Reading:	<input type="checkbox"/> Below grade level	<input type="checkbox"/> On grade level	<input type="checkbox"/> Above grade level
Spelling:	<input type="checkbox"/> Below grade level	<input type="checkbox"/> On grade level	<input type="checkbox"/> Above grade level
Writing:	<input type="checkbox"/> Below grade level	<input type="checkbox"/> On grade level	<input type="checkbox"/> Above grade level
Arithmetic:	<input type="checkbox"/> Below grade level	<input type="checkbox"/> On grade level	<input type="checkbox"/> Above grade level

Has your child ever repeated a grade? _____ If so, when? _____

As best you can recall, please use the following space to provide a general description of your child's school progress, including schools attended. Use the back of this form if extra space is needed. Please attach samples of report cards or yearly testing.

Has your child ever received any of the following?		<input type="checkbox"/> Tutoring	<input type="checkbox"/> Speech/Language Therapy
<input type="checkbox"/> Counseling	<input type="checkbox"/> One-to-one Aid	<input type="checkbox"/> PT	<input type="checkbox"/> Remedial Services
<input type="checkbox"/> Special Education	<input type="checkbox"/> Gifted Testing	<input type="checkbox"/> OT	<input type="checkbox"/> Individual Edu. plan (IEP)
<input type="checkbox"/> 504 Accommodation plan	<input type="checkbox"/> Other (Describe) _____		

Are there any other risk issues, self-harm, or safety concerns?: _____

Signed: _____

Relationship to Child: _____

Date: _____

