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Child and Family History

Form completed by: ( ) Parent ( ) Foster Parent ( ) Guardian ( ) Other ____________

Are you a single parent? ( ) Yes ( ) No

Child's name: _______________________ DOB: ____________ Age: ______

Gender: ( ) Male ( ) Female Grade: ______ Name of School: _______________ How long at this school? ________

Referred by: ( ) Parent/Guardian ( ) Pediatrician ( ) School ( ) Social Services ( ) Court order ( ) Other: ______________

Address: __________________________ City: ______________________ Zip code: _______________

Telephone: Home: __________________ Work: _____________________

Cell:_____________________

Parent's Email Address: _______________________________

It's okay to leave a message at: ( ) Home ( ) Work ( ) Cell ( ) Email Preference: __________________________

Race/Ethnicity: __________________

Emergency contact person: ______________________ Relationship: ____________ Telephone: ____________

Consent for Child Treatment

I am the parent/legal guardian of ____________________ with full legal authority to consent to evaluation and treatment. I hereby give permission for Mindy Parsons, Ph.D., LMHC, to provide treatment for this child which may include assessment, advocacy, referral and mental health counseling.

Signature: ________________________________ Date: ________________________

Print name: _______________________________ Relationship to child: _______________

Signature (2nd parent or guardian): ___________________ Date: ________________________

Print name: _______________________________ Relationship to child: _______________

Type(s) of service desired: ( ) Child therapy ( ) Adolescent therapy ( ) Family therapy ( ) Referral for psychiatric evaluation

Child's main challenge/major reason for seeking help at this time: ____________________________________

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How long has your child been experiencing these problems, symptoms or issues? ____________________________

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Has your child had treatment for these issues in the past? ( ) Yes ( ) No If yes, was the treatment helpful? ( ) Yes ( ) No

Has your child received inpatient mental health treatment? (   ) Yes   (   ) No

Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome: ___________________

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Please describe any other behavior or emotional problems your child is having:

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What is the impact of your child's problems on the family:

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____

What are your child's strengths and unique abilities:

____

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Has your child taken illegal drugs or abused prescription drugs? (   ) Yes (   ) No If yes, please elaborate: ________________

____

Has your child been caught drinking alcohol? (   ) Yes (   ) No If yes, please elaborate:

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Is your child currently under the care of a physician or psychiatrist? (   ) Yes   (   ) No

Treatment for: __________________

If yes, Doctor's name: _________________________________ Telephone number: ___________________

Is your child currently taking any medications? (   ) Yes   (   ) No   If yes, please include the following information:

Name of medication(s)	Dosage	Prescribed by
________________________	___________________	_______________________
________________________	___________________	_______________________

Does your child have a history of abuse (physical, sexual, emotional or neglect)? (   ) Yes   (   ) No

If yes, please describe briefly, including dates, location, perpetrators, type of abuse and impact on child and family: ___________

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Is there legal action pending related to accusations of abuse? (   ) Yes   (   ) No   If yes, please describe: ______________

____

Is there any other legal action that may have impacted your child? Please check all that apply:

	Current	Past		Current	Past
Custody	( )	( )	Visitation	( )	( )
Adoption	( )	( )	Child Protection Services (DCF)	( )	( )
Probation	( )	( )	Other __________________	( )	( )

If yes, please describe:

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Forms of discipline used in the home: ( ) Time out ( ) Loss of privileges ( ) Grounding

( ) Rewards/incentives ( ) Extra chores ( ) Physical/corporal punishment ( )

Other: _______________

BEHAVIOR CHECKLIST

BEHAVIOR	**Current**	**Past**	**BEHAVIOR**	**Current**	**Past**
Crying, sadness, depression			Temper tantrums		
Loss of enjoyment of usual activities			Irritable, angry		
Expressing a wish to die			Argumentative		
Bedtime fears, won't sleep			Disobedient		
Threatened or attempted suicide			Does things that annoy others		
Worries more than others			Unusual fears or phobias		
Panics			Anxious or nervous		
Repeats unnecessary act over and over			Overly concerned about things		
Has rituals, habits, superstitions			Twitches or unusual movements		
Eats very little/fasts to lose weight			Binge eating		
Sleepwalking			Blames others for own mistakes		
Withdrawn			Easily annoyed by others		
Nightmares or night terrors			Swears or uses curse words		
Low self-esteem			Wants to run away		
Wakes early, unable to go back to sleep			Sneaks out at night		
Tiredness, fatigue			Injures self		
Restless sleep, wakes frequently			Stealing		
Difficulty falling asleep			Lying		
Sleeps too much			Hurts animals		

Poor appetite			Destroys property		
Under- or over-weight			Hurts people		
Over-activity			Drug use		
Frequently acts without thinking			Alcohol use		
Doesn't finish things			Cigarette use		
Disruptive			Sexual problems		
Short attention span			Problems with authority		
Daydreams, fantasizes			Problems with the law		
Easily distracted			Low motivation		
Hallucinations (sees/hears things that others don't)			Vomits intentionally		
Bedwetting / daytime accidents			Soiling in pants		
Strange or unusual behavior			Disorientation		
Other ____________________			Other _______________		

Relationship Development (Check each item that describes your child)

	Current	**Past**		**Current**	**Past**
Prefers to be alone			Is demanding and bossy		
Is alone a lot, but dislikes this and feels lonely			Fights with others		
Is shy			Bullies others		
Has few friends			Teases a lot		
Has many friends			Plays with younger kids		
Plays with "problem" kids			Plays with older kids		
Is picked on a lot			Poor relationships with peers		
Is overly sensitive			Conflict with parents/step-parents		
Poor relationships with teachers			Has difficulty getting along with brothers and sisters		

School (Check each item that describes your child)

	Current	**Past**		**Current**	**Past**
Dislikes school			Missed many school days		
Works hard but doesn't do well			Repeated a grade		

Unmotivated, refuses to complete work			Discipline referrals, detentions		
Learning problems			Suspensions		
Expulsions			Other ______________________		

If your child has been suspended or expelled, please explain:

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Relationship Development (Check each item that describes your child)

	Current	Past		Current	Past
Resource classes / special ed.			Continuation school		
Gifted program			Home study		
Speech therapy			Independent study		
Other programs					

If other programs apply, please explain:

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Family Stressors (Check each item that describes your child)

	Current	Past		Current	Past
Marital problems			Housing problems		
Marital separation			Legal issues		
Divorce			Death of a friend		
Custody disputes			Death of a relative		
Financial problems			Death of a pet		
Job loss			Family illness		
Parents using alcohol/drugs			Other stressors: ________________		

If other stressors are present, please explain:

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Developmental History During pregnancy, did the child's mother experience any of the following:

( ) alcohol ( ) drugs ( ) illness ( ) accident

( ) problems with pregnancy ( ) problems with labor ( ) problems with delivery ( ) premature delivery

If yes to any of the above, please explain:

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Please check if child is/was delayed in any of the following areas: ( ) holding head up ( ) turning over ( ) sitting up

( ) crawling ( ) walking alone ( ) weaning ( ) feeding him/herself ( ) potty training ( ) using single words

( ) using sentences ( ) dressing him/herself ( ) sleeping through the night

Please briefly explain any delays:

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As a baby/toddler, was the child (check all that apply):

( ) eating well ( ) colicky ( ) head banging ( ) performing rocking behavior ( ) clumsy

( ) wanting to be left alone

( ) easy to regulate (sleeping/eating) ( ) adaptable to transitions ( ) more interested in things than people ( ) easy to soothe

( ) performing daredevil behavior

Medical History (Indicate if your child has had any of the following):

Condition	Yes	No	Age	Details
Serious infection				
Convulsions/seizures				
Head injuries				
Other injuries				
Hospitalizations				
Surgeries				
Ear infections				
Poisonings				
Allergies				
Asthma				
Alcoholism				
Drug Use				

Does your child have any other medical conditions? (   ) Yes   (   ) No

If yes, please describe:

____

____

Does your child frequently complain of body aches and pains? (   ) Yes   (   ) No

If yes, please describe:

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Does your child miss school because of his/her physical complaints? (   ) Yes   (   ) No

If yes, please describe:

____

____

Does your child have any allergies to medications, drugs or foods? (   ) Yes   (   ) No

If yes, please describe:

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Family information: Please list all of the people who currently live with the child:

Name	Age	Relationship	Occupation/School & Grade

Indicate if any family members or relatives have the following:

	Mother	**Father**	**Brother**	**Sister**	**Other (please specify) (aunts, uncles, cousins, grandparents, etc.)**
Problems with attention, activity or impulse control as a child					
Learning disabilities					
Did not graduate from High School					
Alcohol abuse					
Drug use					
Problems with aggression					
Antisocial behavior (arrests, jail, legal problems, probation, hurting animals, etc.)					
Abuse victim					
Abusive to others					
Depression					
Nervous disorders (anxiety)					
Mental retardation					
Serious illness or surgeries					
Physical handicaps					
Tics or unusual movements					
Other mental health problems					

What are your family supports? (church, friends, relatives, clubs, etc.)

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What are your family's strengths?

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Please list any adults who are authorized to drop off or pick up your child from his or her therapy session in the event you or another legal guardian are unavailable:

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Please note: An authorized adult must remain in the waiting room at all times when a minor is in a therapy session.

I authorize the above named person(s) to bring my child from his/her therapy session. I agree that I or any person named by me (listed above) will not leave the premises and will remain in the waiting room for the duration of my child's therapy session.

______________________________	______________________
Child's name	DOB
______________________________	______________________
Print Parent/Guardian Name	Relationship to child
______________________________	______________________
Signature	Date