



CHILDHOOD HISTORY FORM

Child's Name _____ Date _____

Birthdate _____ Age _____ Sex _____

Adopted ___ yes ___ no Is your child aware of adoption? ___ yes ___ no

Divorce? Yes _____ no _____ When? _____

If divorced, describe your relationship with child's other biological parent _____

Others in Household:	Relationship to child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly state your main concerns about your child and the duration:

What do you think might be causing this?

Has anyone else expressed concerns about your child?

Have any of the child's blood relatives experienced similar problems?

What are your expectations for therapy?

Has your child ever been seen by another counselor? Yes _____ No _____

Dates _____ Who? _____

Outcome _____

Who will participate in child's therapy? Mom: yes ___ no ___ Dad: yes ___ no ___
 Step Mom: yes ___ no ___ Step Dad: yes ___ no ___

Anything that caused either parent significant unhappiness or worry during child's first three years? _____

Biggest struggle in your family's history _____

Current stressors in family _____

Parental unemployment? Dates: _____

Any deaths your child has experienced? _____

Any moves? If so, when and where _____

Child exposed to disaster? Describe _____

What are the child's responsibilities? _____

Who is your child like? _____

What are your child's strengths? _____

What makes your child mad? _____

What are your child's favorite activities? _____

What does your child dislike doing the most? _____

Describe your child's temperament _____

Did the child's mother or the child experience any complications during pregnancy/delivery?

MEDICAL HISTORY Please note the age and any other pertinent information. Use back if necessary.

Childhood diseases: _____

Operations: _____

Other hospitalizations: _____

Head injuries: _____

Convulsions/seizures: _____

Persistent high fevers: _____

Eye problems: _____

Tics (eye blinking, sniffing, or any repetitive movement): _____

Ear problems: _____

Allergies or asthma: _____

Sleep problems (restless, night waking, sleepwalking): _____

Bedwetting or soiling pants in daytime: _____

Describe the child's appetite: _____

Please list other doctors or professionals consulted: _____

Current medications and dose: _____

FAMILY/SOCIAL HISTORY

Include any brothers or sisters you (the parent) have/had as well as your (the parent) natural parents (In other words, YOUR childhood history). Be sure to include PAST or PRESENT behavior.

Birth Mother Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |

Birth Father Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |

Step-Mother Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |

Step-Father Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |

Adopted Mother Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |

Adopted Father Childhood History (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug Usage |
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Criminal Activity | <input type="checkbox"/> Homosexuality |

Which family member has the best relationship with the patient? _____

INFANCY - TODDLERHOOD

Were any of the following present during your child's first few years?

- | | |
|---|---|
| <input type="checkbox"/> did not enjoy cuddling | <input type="checkbox"/> was not calmed by being held |
| <input type="checkbox"/> difficult to comfort | <input type="checkbox"/> colic |
| <input type="checkbox"/> excessive restlessness | <input type="checkbox"/> excessive irritability |
| <input type="checkbox"/> frequent head banging | <input type="checkbox"/> constantly into everything |

TEMPERAMENT: please rate the following as your child appeared in infancy and toddlerhood:

- Activity level: underactive average activity level overactive
- Adaptability: adapted easily to change resisted change
- Intensity: average feelings were often intense
- Mood: often happy average range of moods
- often dissatisfied or irritable

DEVELOPMENTAL MILESTONES

As best you can recall, list age of development, or check item at right:

	Age	or	Early	Normal	Late
Walked without assistance	_____		_____	_____	_____
Spoke first words	_____		_____	_____	_____
Any speech/articulation problems?					
Toilet trained daytime	_____		_____	_____	_____
Toilet trained nighttime	_____		_____	_____	_____

COORDINATION

Rate your child on the following skills:

	Good	Average	Poor
Walking	_____	_____	_____
Running	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Shoelace tying	_____	_____	_____
Writing	_____	_____	_____
Athletic abilities	_____	_____	_____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions and situations as well as other children his/her age?

How would you rate your child's overall level of intelligence?

- Below average Above average Average

PEER RELATIONSHIPS

How does your child get along with others his/her age? Describe any problems.

SCHOOL HISTORY

School currently attending: _____ Grade level _____

Is your child in any resource or special classes? _____

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

Briefly describe your child's school progress. Note usual grades, any problems or successes, strong subjects and weak subjects:

Preschool - K _____

1st - 5th _____

6th - 8th _____

9th - 12th _____

Describe any conduct problems your child has had in school:

How would you rate your child's homework/study skills? ___ Good ___ Average ___ Poor

Describe difficulties: _____

Has your child had tutoring or remedial work? _____

Does your child like to read? _____ How often (circle one) Never Seldom Occas. Often

Please rate reading ability as _____ good _____ fair _____ poor

Any other comments on your child's performance and behavior:

HOME BEHAVIOR AND MOOD

Check which of the following applies to your child:

- | | |
|---|--|
| <input type="checkbox"/> frequently irritable or moody | <input type="checkbox"/> nervous, anxious |
| <input type="checkbox"/> can't seem to enjoy doing anything | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> sad spells | <input type="checkbox"/> frequent stomachaches |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> has had a panic attack (rapid heartbeat, sweaty palms, feeling something bad about to happen) |
| <input type="checkbox"/> easily bored | <input type="checkbox"/> difficulty sleeping:
<input type="checkbox"/> goes to sleep very late
<input type="checkbox"/> hard to get up in morning
<input type="checkbox"/> very restless sleep
<input type="checkbox"/> bad dreams |
| <input type="checkbox"/> poor or low motivation | <input type="checkbox"/> acts like driven by a motor |
| <input type="checkbox"/> low self-esteem (makes negative statements about self) | <input type="checkbox"/> doesn't seem to learn from experience |
| <input type="checkbox"/> can't seem to concentrate | <input type="checkbox"/> very disorganized (loses things, has very messy room) |
| <input type="checkbox"/> has had thoughts of or made comments about suicide | <input type="checkbox"/> has ever been physically or sexually abused |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> drug or tobacco use: _____ |
| <input type="checkbox"/> eats (too much) or (too little) | <input type="checkbox"/> argues with or rude to teachers |
| <input type="checkbox"/> frequent arguing at home | |
| <input type="checkbox"/> fearfulness | |

Any additional comments you would like to make about your child (mood, behavior, personality, etc.):

Thank you for the time and effort you gave in completing this form. Please also complete any check lists which accompany this history form.

Most children exhibit, at one time or another, one or more of the symptoms listed below. Place a P next to those that your child has exhibited in the PAST and N next to those that your child exhibits NOW. Only mark those symptoms that have been or are present to a significant degree over a period of time. Only check as problems behavior that you suspect is unusual or atypical when compared to what you consider to be the normal for your child's age.

- _____ Thumb-sucking
- _____ Baby Talk
- _____ Overly dependent for age
- _____ Frequent temper tantrums
- _____ Excessiveness silliness and clowning
- _____ Excessive demands for attention
- _____ Cries easily and frequently
- _____ Generally immature
- _____ Eats non-edible substances
- _____ Overeating with overweight
- _____ Eating binges with overweight
- _____ Under eating with underweight
- _____ Long periods of dieting and food abstinence with underweight
- _____ Preoccupied with food--what to eat and what not to eat
- _____ Preoccupation with bowel movements
- _____ Constipation
- _____ Encopresis (soiling)
- _____ Insomnia (difficulty sleeping)
- _____ Enuresis (bed wetting)
- _____ Frequent nightmares
- _____ Night terrors (terrifying night time out bursts)
- _____ Sleepwalking
- _____ Excessive sexual interest and preoccupation
- _____ Frequent sex play with other children
- _____ Excessive masturbation
- _____ Frequently likes to wear clothing of the opposite sex
- _____ Exhibits gestures and intonations of the opposite sex
- _____ Frequent headaches
- _____ Frequent stomach aches
- _____ Frequent nausea and vomiting
- _____ Often complains of bodily aches and pains
- _____ Worries over bodily illness
- _____ Poor motivation
- _____ Apathy
- _____ Takes path of least resistance
- _____ Ever trying to avoid responsibility
- _____ Poor follow through
- _____ Low curiosity
- _____ Open defiance of authority
- _____ Blatantly uncooperative
- _____ Persistent lying
- _____ Frequent use of profanity to parents, teachers, and other authorities
- _____ Truancy from school
- _____ Runs away from home
- _____ Violent outbursts of rage
- _____ Stealing
- _____ Cruelty to animals, children, and others
- _____ Destruction of property
- _____ Criminal and/or dangerous acts
- _____ Trouble with the police

- _____ Violent assault
- _____ Fire setting
- _____ Little, if any, guilt over behavior that causes others pain and discomfort
- _____ Little, if any, response to punishment for antisocial behavior
- _____ Few, if any, friends
- _____ Does not seek friendships
- _____ Rarely sought by peers
- _____ Not accepted by peer group
- _____ Selfish
- _____ Argumentative
- _____ Does not respect the rights of others
- _____ Wants things own way with exaggerated reaction if thwarted
- _____ Trouble putting self in other person's position
- _____ Egocentric (self-centered)
- _____ Frequently hits other children
- _____ Excessively critical of others
- _____ Excessively taunts other children
- _____ Ever complaining
- _____ Is often picked on and easily bullied by other children
- _____ Suspicious, distrustful
- _____ Aloof
- _____ "Wise-guy" or smart aleck attitude
- _____ Brags or boasts
- _____ Bribes other children
- _____ Excessively competitive
- _____ Often cheats when playing games
- _____ "Sore Loser"
- _____ "Does not know when to stop"
- _____ Poor common sense in social situations
- _____ Often feels cheated or gypped
- _____ Feels others are persecuting him when there is no evidence for such
- _____ Typically wants his or her own way
- _____ Very stubborn
- _____ Obstruction-istic
- _____ Negativistic (does just the opposite of what is requested)
- _____ Quietly, or often silently, defiant of authority
- _____ Feigns or verbalizes compliance or cooperation but does not comply with requests
- _____ Drug abuse
- _____ Alcohol abuse
- _____ Very tense
- _____ Nail biting
- _____ Chews on clothes, blankets, etc.
- _____ Head banging

- _____ Hair pulling
- _____ Picks on skin
- _____ Speaks rapidly and under pressure
- _____ Irritability, easily "flies off the handle"

FEARS/PHOBIAS

- _____ dark
- _____ new situations
- _____ strangers
- _____ being alone
- _____ death
- _____ separation from parent
- _____ school
- _____ visiting other children's homes

- _____ going away to camp
- _____ animals
- _____ other fears (name)
- _____ Anxiety attacks with palpitations (heart pounding), shortness of breath, sweating, etc.
- _____ Disorganized
- _____ Excessive worrying over minor things
- _____ Tics such as eye blinking, grimacing, or other spasmodic repetitious movements
- _____ Involuntary grunts, vocalizations (understandable or not)
- _____ Stuttering
- _____ Depression
- _____ Frequent crying spells
- _____ Suicidal preoccupation, gestures, or attempts
- _____ Excessive desire to please authority
- _____ "Too Good"
- _____ Often appears insincere and/or artificial
- _____ Too mature, frequently acts older than actual age
- _____ Excessive guilt over minor indiscretions
- _____ Asks to be punished
- _____ Low self-esteem
- _____ Excessive self-criticism
- _____ Very poor toleration of criticism
- _____ Feelings easily hurt
- _____ Dissatisfact-ion with appearance or body part(s)
- _____ Excessive modesty or exposure
- _____ Perfectionist, rarely satisfied with performance
- _____ Frequently blames others as a cover up for own short comings
- _____ Little concern for personal appearance or hygiene
- _____ Little concern for or pride in personal property
- _____ "Gets hooked" on certain ideas and remains preoccupied

- _____ Compulsive repetition of seemingly meaningless physical acts
- _____ Shy
- _____ Inhibited self expression in dancing, singing, laughing, etc.
- _____ Recoils from affectionate physical contact
- _____ Withdrawn
- _____ Fears asserting self
- _____ Inhibits open expression of anger
- _____ Allows self to be easily taken advantage of
- _____ Frequently pouts and/or sulks
- _____ Mute (refuses to speak) but can
- _____ Gullible/naive
- _____ Passive and easily led
- _____ Excessive fantasizing, "lives in his (her own world"
- _____ Flat emotional tone
- _____ Speech is non- communicative or poorly communicative
- _____ Hears voices
- _____ Sees visions