

DELTA FAMILY CLINIC SOUTH, P.C.
CHILD HISTORY FORM

Child's full name: _____ **Birth Date:** _____ **Date:** _____
Nickname, if any: _____ **Age:** _____ **Sex:** _____
Address: _____ **Phone:** _____
Guardian's Name (if different from parent): _____

- Please note all **bolded** questions must be filled out, including the relevant information associated with each statement.

Email Address of patient/parent or guardian:

As of 2012 we would like to accommodate patients with using E-mail as a source of communication. If applicable please provide your current E-mail address below.

_____ @ _____

Statement of problem/reason for appointment (including any specific reasons for seeking help at this time):

Who referred you to Delta Family Clinic? (If a primary care/ specialty doctor please provide street name/address or location.)

I. FAMILY HISTORY:

Mother's name: _____ Birth Date: _____
Occupation: _____ State of Health: _____
Father's name: _____ Birth Date: _____
Occupation: _____ State of Health: _____

Are both parents in the home? _____ **Death of one parent?** _____
Separated or Divorced? _____ **Visits by other parent?** _____ **How often?** _____
Step-parent? _____ **Foster parent?** _____ **Age of child at death or divorce?** _____
Age of child at remarriage? _____ **Length of present marriage?** _____

Brothers and Sisters (Please list all children: step and half-sister and/or brothers)

Please put a check next to name if out of home.

Name	Birth date	Age	Areas of Difficulty in School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in home: (give age and relationship) _____

State in your own words the nature of your child's main problems: _____

Has your child ever had any of the following evaluations?

Psychological_____	Where_____	When_____
Speech_____	Where_____	When_____
Hearing_____	Where_____	When_____
Eye_____	Where_____	When_____
Neurological_____	Where_____	When_____
Physical_____	Where_____	When_____

Does your child have any handicaps (visual, auditory, speech, language, muscular)? If so, explain:_____

II. BIRTH AND PRENATAL HISTORY:

Is the child adopted?_____ If yes, at what age?_____

Did the mother receive prenatal care?_____

If yes, which month did the mother first see a doctor?_____

During this pregnancy, did the mother have any unusual illnesses, conditions, accidents, such as German measles, false labor spotting, swelling or water retention, toxemia, RH incompatibility, diabetes, etc? If so, describe: _____

Any medications taken during pregnancy? _____ **if yes, what?** _____

Hours of labor:_____ Was labor induced?_____

Length: full term, premature, post mature (number of months long) _____

Delivery: C Section, instruments used (forceps), easy, difficult, normal? _____

Did child's head or feet come first? _____ was the mother awake? _____

Birth weight: _____ Length: _____

After birth, was the child blue? _____ Jaundiced (yellow)? _____

Bruised or scarred? _____ Other? (state what) _____

Any sucking or swallowing problems? _____

Did the infant have breathing problems? _____ How long? _____

Any feeding problems? _____ If yes, please explain: _____

III. DEVELOPMENT:

State the age at which your child did these things: Is this from memory or record (circle one)?

Held head up _____ Sat alone _____

Crawled _____ Pulled up to a standing position _____

Walked alone _____ Breast fed to age _____

Bottle fed to age _____ Self weaned? _____

Used a spoon _____ fork _____ Drank from glass or cup _____

Ate solid food _____ Special diet needs _____

Babbled _____ Used gestures meaningfully _____

Single words _____ Phrases _____

Completed Sentences _____

Training information:

Bladder control: Day _____ Training started _____

Night _____ Training finished _____

Bowel control: Day _____ Training started _____

Night _____ Training finished _____

Daytime accidents to age _____ Night time accidents to age _____

Patient Name: _____ DOB: _____

How did his/her growth compare with that of his/her siblings? Describe: _____

IV. HEALTH HISTORY:

Please indicate the age your child experienced these things, and whether they were mild, average, severe, and if there were any after effects.

Measles _____	High fevers _____	Chicken pox _____
Head injury _____	Mumps _____	Heart disease _____
Whooping cough _____	Rheumatic fever _____	Allergies _____
Hay fever _____	Tuberculosis _____	Asthma _____
Meningitis _____	Eczema _____	Kidney Disease _____
Pleurisy _____	Nerve Disorder _____	Muscle Disorder _____
Hives _____	Frequent Colds _____	Paralysis _____
Croup _____	Cerebral Palsy _____	Tonsillitis _____
Epilepsy _____	Influenza _____	Seizures _____
Ear Ache _____	Enlarged Glands _____	Hearing Problems _____
Tongue Tie Clip _____	Eye Problems _____	Poisoning _____
Overweight _____	Diphtheria _____	Underweight _____
Typhoid _____	Staring Spells _____	Dysentery _____
Fainting Spells _____	Suicide Attempts _____	

Does anyone in the family have a history of the above or any other illness of handicap? If so please explain _____

Immunization	In process	Complete	None	Reaction (if any)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family (or child's) physician (if you have one) _____

Please describe any serious accidents or operations the child has had: _____

Please list any long term medications taken (previous and current) _____

Current state of child's health: _____

V. APPETITE:

Does the child have a good appetite? _____ **How many meals does the child eat each day?** _____

Is there excessive snacking? _____ **Excessive sugar eaten?** _____

VI. SLEEPING HABITS:

Usual number of hours of sleep _____ **naptime?** _____ **Bedtime?** _____

Time child goes to bed? _____ **Time child gets up in the morning** _____

Does the child seem to require a lot of sleep (more than 12 hours a day)? _____

Does the child seem to require little sleep (less than 8 hours a day)? _____

Where does the child usually sleep (crib, junior, adult bed)? _____

Patient Name: _____ DOB: _____

Does child sleep alone? _____ Does child sleep well? _____
 Does the child have any routine at bedtime? _____ if so, please explain: _____

Any sleeping problems (nightmares, sleepwalking, etc.)? _____

VII. SOCIAL DEVELOPMENT:

How does the child get along in the home? _____

How does the child get along with the mother? _____

Father? _____ Brothers? _____

Sisters? _____ Adults? _____

Strangers? _____ Children child's own age? _____

Younger? _____ Older? _____

Pets? _____

Do you see any changes occurring? _____

Time spent watching T.V. each day? _____

Any strong attachment outside the home? _____

Does child dress self? _____ How much help does child need? _____

Does child ever put wrong arm in sleeve? _____ Does child select clothes to wear? _____

Can child leave yard? _____ Permission required? _____

What kind of toys and play does the child like most? _____

By self? _____ With others? _____

What does your child like to do for fun? _____

Does child help with simple jobs, such as picking up toys? _____

What chores? _____

Does child share feelings easily? _____ Toys? _____ Pain? _____ Anger? _____

Any fears (describe): _____

Any previous nursery school experience? _____

Does the child experience mood cycling? _____ **If yes, explain:** _____

Does the child experience mood changes without the presence of precipitants? _____

Please check the corresponding lines if your child is described by any of the following:

_____ very active	_____ frequent accidents, tripping, falling
_____ very calm, quiet	_____ loses balance easily
_____ restless	_____ unusual walk
_____ difficulty sitting still	_____ right handed
_____ nervous or tense	_____ left handed
_____ affectionate	_____ uses both hands alternately
_____ good natured	_____ has handedness been changed?
_____ easily angered	_____ grew rapidly
_____ cries easily	_____ grew slowly
_____ frequent mood changes	_____ difficulties chewing or swallowing
_____ rocks body back & forth	_____ long periods of little or no growth
_____ when sitting	_____ speech difficulties (describe) _____
_____ rocks body when standing	_____ poor eating habits (describe) _____
_____ uncontrolled facial jerks	_____ frequently ill
_____ clumsy, awkward	

Patient Name: _____ DOB: _____

VIII. DISCIPLINE:

What type of discipline do you use most often? _____
 talk with child? _____ physical? _____ persuasion? _____
 reasoning _____ taking away privileges _____ other? _____

Who disciplines most? _____ Agreement on discipline? _____

Any big change in discipline methods by you or others? _____

Do you have any problems with management or controlling your child? Please describe: _____

Describe your child's reaction to discipline (does it work): _____

IX. SCHOOL:

Current grade level in school? _____ **Average grades received: last term:** _____ **now:** _____

Current goals in school _____

How does child get along with children in school? _____

Special Education? Yes _____ No _____

At what grade did Special Education begin? _____ **End?** _____

Why is the child in Special Education? _____

Has the child ever been held back or skipped a grade? Yes _____ No _____

Which grade? _____ **What reason?** _____

Any problems in school behavior reported to you by teachers? Yes _____ No _____

Describe the reported problem: _____

Any suspensions? Yes _____ No _____ **If yes, why?** _____

When did suspensions begin? Grade _____

Has child ever been in trouble due to stealing? _____ **Use of drugs/alcohol?** _____

Threatening other students? Explain: _____

X. PREVIOUS PSYCHOLOGICAL TREATMENT:

Please list any therapists and agencies the child has been in treatment with (inpatient or outpatient) as well as the beginning and ending dates of treatment and the reason for treatment:

Where	When	Start Date	End Date	Reason for Treatment
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

XI. JUVENILE HISTORY:

Has there ever been a time your child has been arrested and appeared in Juvenile Court? _____

Explain: _____

Does your child have any history of being removed from your care and placed in Foster Care? _____

Explain: _____

Patient Name: _____ DOB: _____

XII. ADDITIONAL COMMENTS OR CONCERNS:

XIII. PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR CHILD:

1. **Please specify why the child is being referred. State any questions you would like answered:** _____

2. **Any specific background information or behavior that led to the referral?** _____

3. **When did the problem start?** _____

4. **Was there anything that happened at the time the problem began that might be related to the difficulty?** _____

Please list any friends or family members who you think will be supportive of the patient's treatment.

Name of person(s):

What else would you like to tell us or think we should know about this patient and their current difficulties?

Signature (Parent and/or Legal Guardian)

Date

Reviewing Clinician Signature

Date

Patient Name: _____ DOB: _____