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_____

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_____
Whopping 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)_____

Has this child ever been abused, abandoned, neglected, or exploited in any way? Yes / No If yes, please explain: _____

_____

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)? _____
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? _____

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

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

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

_____

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

_____

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:_____
_____

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: _____