

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 _____

<u>Immunization</u>	<u>In process</u>	<u>Complete</u>	<u>None</u>	<u>Reaction (if any)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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?** _____

Patient Name: _____ DOB: _____

VI. SUBSTANCE USE/ABUSE:

Please note the usage of any of the following substances:

	If yes, age of first use:	Method of Use: (injected, Inhaled, Ingested, Snorted)	Date/Age last used:	Amount used in last 30 days:	Amount used in the last 48 hours:
Alcohol					
Sedatives					
Cannabis					
Stimulants					
Cocaine					
Opioids					
Hallucinogens					
Other					

Examples:Alcohol: Beer, wine, liquor, mixed drinks, coolers:Sedatives-hypnotics-tranquilizers: Seconal, Valium, Xanax, Librium, Barbiturates, Miltown, Ativan, Dalmane, Halcion, Restoril, Reds, Yellos, Placidyl, Klonopin, Phenergan, Phenobarbital, Tuinal, Nembutal, Quaalude, or other:Cannabis: Marijuana, Hashish, Liquid THC, or other:Stimulants: Amphetamine, Speed, Crystal Meth (Crank), Dexedrine, Ritalin, Ice, Black Beauties, Preludin (Bam), crossroads, or other:Cocaine: Freebase, Crack, "Speedball," Powder, or other:Opioids: Heroin, Opium, Morphine, Methadone, Darvon, Codeine, Percodan, Demerol, Dilaudid, Cough Syrup w/ codeine, Dolophine, Tylox, Tylenol #3 or #4, Pantapone, or other:Hallucinogens/PCP: LSD (Window pane, Acid, Microdot), Mescaline, Peyote, Psilocybin, STP, Mushrooms, PCP (Angel dust, Flakes, Greens), Ecstasy, MDMA, MDA, or other:Other: Steroids, Glue, Paint, Nitrous Oxide (Laughing gas), Amyl or Butyl Nitrate (poppers, rush), Nonprescription sleep or diet pills, Clonidine, Elavil, Sinequan, Excedrin, NoDoz, Dexatrim, Caffeine, Quick-Pep, Vivarin, or other:**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? _____

Patient Name: _____ DOB: _____

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	_____ 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	

Do you experience mood cycling (i.e. mood swings that quickly go from low to high and back again, and occur over periods of a few days and sometimes even a few hours)? No Yes

If yes, explain: _____

Does the child experience mood changes without obvious cause? No Yes If yes, explain: _____

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? _____

Patient Name: _____ DOB: _____

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:

Patient Name: _____ DOB: _____

