FAMILY HISTORY (2)

This form is a method of providing Dr. Wade with important information about the client (your child) and his/her family. Data about the child and his/her family will provide a more complete picture from which to assess your child's needs and conduct treatment. Please take the time to thoroughly complete this form. The information is confidential with the same privileges and limitation as outlined in the confidentiality section of the intake packet.

IDNETIFICATION:

Client's Name: _______
D.O.B.: _____
Form completed by: _____
Today's Date: _____

.

What brings you here today?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Goals for Child/Family

1._____

_____

2._____

_____

3._____

_____

A. FAMILY:

Blended? ___ Yes ___ No If yes, list dates of family changes, names and roles of adults in child's life.

Father:_____ Mother:_____

Occupation:_____ Occupation:_____

Education:_____ Education:_____

Age:_____ Age:_____

If separated or divorced list dates: _____ Who has legal custody? _____

Step-parent or care taker: Step-parent or care taker:

_____ _____

Occupation:_____ Occupation:_____

Education:_____ Education:_____

Age:_____ Age:_____

Date joined family:_____ Date joined family:_____

Step-parent or care taker: Step-parent or care taker:

_____ _____

Occupation:_____ Occupation:_____

Education:_____ Education:_____

Age:_____ Age:_____

Date joined family:_____ Date joined family:_____

Siblings:

Indicate if: biological (B), step (S), half (H) sibling to the client.

Name	**Age:**	**Sex:**	**In or out of the home:**
_____	Age:_____	Sex:_____	In_____Out_____
_____	Age:_____	Sex:_____	In_____Out_____
_____	Age:_____	Sex:_____	In_____Out_____
_____	Age:_____	Sex:_____	In_____Out_____
_____	Age:_____	Sex:_____	In_____Out_____
_____	Age:_____	Sex:_____	In_____Out_____

BIRTH OF YOUR CHLD: (circle all that apply)

Planned Unplanned Wanted Unwanted

Did mother see her physician regularly? ____Yes ____No How often?_____

How far along was the pregnancy when mother realized she was pregnant?_____

Prior to the pregnancy mother used: **(Circle)** Tobacco Alcohol Caffeine
Over-the-Counter Medications
Prescription Medications
Marijuana Other drugs

During the pregnancy mother used: **(Circle)** Tobacco Alcohol Caffeine
Over-the-Counter Medications
Prescription Medications
Marijuana Other drugs:_____

List the names of drugs used during pregnancy, how ingested, frequency and amount of use:

_____

_____

_____

Was the pregnancy normal? ____Yes ____No (if no describe)

_____

_____

Was the birth normal? ____Yes ____No (if no describe)

_____

_____

Length of pregnancy: _____Length of labor:_____

Birth weight: _____Birth length:_____

List any abnormalities. (i.e., medications the baby needed, illness, physical defects, etc.)

_____

_____

Location of birth. I.e. name of hospital or other location, city, state, country:

_____

_____

FIRST YEAR: How would you describe your child?

Activity level: **(circle)**

Constantly moving Moderately active Inactive

When faced with change: **(circle)**

Easily upset took time to adjust Quick to adapt

In an emotional situation (pleasant or unpleasant) reaction was: **(circle)**

Intense Moderate Bland

In most situations, baby's mood was: **(circle)**

Cheerful Variable Negative

The time span the baby focused attention on one thing was: **(circle)**

Long Moderate Short

Was the baby cuddly? ____Yes ____No

Patterns during first year: **(Circle all that apply)**

Colic Allergies Frequent vomiting Frequent/prolonged crying Sleeping problems

Was your child breast-fed? ____No ____Yes Up to what age? _____

Please check and date any <u>concerns</u> in the following milestones:

_____ Respond to sound _____Use first clear words

_____ Stand alone _____Use cup/spoon

_____ Crawl _____Walk alone

_____ Give up bottle _____Remain dry during day

_____ Dress self _____Remain dry at night

_____Complete bowel training

What hand does the child prefer? **(circle)** Right Left Both

Coordination is: **(circle)** Poor Average Good

B. HEALTH INFORMATION:

Who is your child's primary care provider (Doctor, P.A., Etc.)?_____

When was your child's last physical?_____

Does your child have any chronic health problems, including allergies? ____Yes ____No

If yes list conditions and interventions/treatments_____

_____

_____

Is he or she currently taking and medications? ____Yes ____No

If yes list prescribing physician, name of medication, amounts and how long has he or she been on the medications_____

_____

Chronic Pain? ____Yes ____ No

Has your child ever suffered from a head injury? ____Yes ____ No

If yes explain the injury, treatment and approximate date_____

_____

Has your child ever met with a mental health therapist or drug and alcohol therapist? ____No ____ Yes

If yes with whom, where, when, duration of treatment, reason for treatment and outcome._____

_____

NOTE: Limits on confidentiality which may need to be reported to authorities: history of abuse or imminent danger to self or others.

Past or current Challenges for your child:

Sad	☐	Fear from traumatic experience	☐
Anxiety	☐	Panic Attack (intense fear)	☐
Anger Problem	☐	Avoidance of going places due to fear	☐
Tantrums	☐	Oppositional	☐
Cries easily	☐	Isolates	☐
Hallucinations	☐	Phobias	☐
Obsessive/Compulsive	☐	Paranoia	☐
Mood Swings	☐	Sleeping 4 or less hour's night feeling rested	☐
Self harm	☐	Suicidal Thoughts	☐
Harming others	☐	Homicidal Thoughts	☐
Hyperactivity	☐	Attention problems	☐
Impulsive	☐	Lack of remorse/empathy	☐
Fire setting	☐	Cruelty to animals	☐
Sexualized behavior	☐	Excessive computer use	☐
Victim of sexual abuse	☐	Victim of physical abuse	☐

List any family history of mental illness (e.g.; depression, anxiety, schizophrenia, hospitalization, etc.)

_____

_____

_____

List any legal involvement your child has had and if he or she is currently involved with the law including involvement with Services to Children & Families.

_____

_____

_____

_____

Average screen time: Week day ____ Weekend _____ Computer/screens in bedroom Yes N0

Please list any concerns regarding computer or screen time regarding your child.

_____

_____

Has your child experimented with or had problems with drugs and/or alcohol to your knowledge?
____Yes ____No If yes, explain.

_____

_____

List any family history of problems with drugs or alcohol. _____

_____

_____

List any major family changes, stressors or family values that you believe impact your child.

_____

_____

List any religious and/or cultural beliefs practiced in the home. _____

_____

List some of your child's strengths . _____

_____

_____

C. SCHOOL INFORMATION:

Name of school:_____

Name of teacher:_____

Grade in school:_____

Is your child working at grade level? ____Yes ____ No

If no explain. _____

_____

Have there been any major changes in the grades of your child receives? ____Yes ____No

If yes explain:_____

_____

Has your child ever received special classes or been on an Individual Education Plan? ____ Yes ____ No
Talented & Gifted Program? ____ Yes ____ No

If yes explain and provide years and types of services: _____

_____

_____

Has your child received referrals or been suspended from school? ____ Yes ____ No

If yes, when, what caused the suspension/referral, how many times has he/she been suspended or referred? _____

_____

_____

Has your child ever repeated a grade? ____ Yes ____ No

If yes, which grade and how did he or she respond? _____

_____

_____

How does your child get along with other children at school? Good Fair Poor

How does your child get along with teachers at school? Good Fair Poor

List your child's strengths at school: _____

ADDITIONAL INFORMATION YOU BELIEVE MAY BE HELPFUL TO YOUR CHILD'S TREATMENT: _____

_____

_____

_____

_____

_____

_____

Thank You