CFCG ~ **THE CHILD & FAMILY COUNSELING GROUP, P.L.C.**

Comprehensive Diagnostic & Therapeutic Services

PATIENT HISTORY FORM
CHILD & ADOLESCENT

Patient Name: _____ Date of Birth: _____

Form completion date: _____ Gender: M F (circle one)

Name of person completing this form: _____ Relation to patient: _____

Home Address: _____Phone:_____
_____

School: _____ Grade:_____

How were you referred to The Child and Family Counseling Group?
_____

What concerns do you have with your child?_____
_____
_____
_____

How long has this problem(s) existed? Years Months (circle one)

What have you been told by others regarding your child's difficulties?_____
_____
_____
_____

What can we do to help you and your child?_____
_____
_____
_____

Is the family intact? Yes No (circle one)

Who lives in the home?

Name	Age	Relationship	Education Level	History of emotional or learning difficulties
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
4._____	_____	_____	_____	_____
5._____	_____	_____	_____	_____
6._____	_____	_____	_____	_____
7._____	_____	_____	_____	_____

Mother: _____
Occupation: _____
Health Status:_____

Father: _____
Occupation: _____
Health Status:
_____

BLENDED, SEPERATED DIVORCED FAMILIES PLEASE COMPLETE THE FOLLOWING:

When did the divorce/separation occur?
_____

Who is the custodial parent? _____

Where is the non-custodial parent? _____

Mother's Marital History

Dates (FROM-TO)	Spouse's Name	How did the marriage end?
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Father's Marital History

Dates (FROM-To)	Spouse's Name	How did the marriage end?
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Mother's Children		Father's Children	
Name	Date of Birth	Name	Date of Birth
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____
8._____	_____	_____	_____
9._____	_____	_____	_____

If not remarried, does mother have significant other? Yes No (please circle)
If yes, who? _____ How long? _____

If not remarried, does father have significant other? Yes No (please circle)

If yes, who? _____ How long? _____

Developmental and Health History

Was the child from a planned pregnancy? Yes No (please circle)
Was the child adopted? Yes No (please circle one) How old was the child? _____
Were there any problems during the pregnancy? (I.e. toxemia, diabetes, high blood pressure, etc.)
_____
_____
_____

Were there any problems during the delivery?
-
_____
_____
_____

Were there any problems during the first 3 months post-delivery? (I.e. feeding, sleeping, breathing problems, other)
_____
_____
_____

Did the child attain developmental milestones at expected age?

Set alone_____ Crawled_____
Toilet Training started _____ Toilet Training ended_____
Stood Alone_____ Walked without holding_____
Rode Tricycle_____

Has the child had any of the following diseases?
Measles No Yes Age(s) _____
Mumps No Yes Age(s) _____
Chicken Pox No Yes Age(s) _____
Strep Throat No Yes Age(s) _____
Ear Infections No Yes Age(s) _____

Please list present medication(s) and dosages:

Name	Dosage	Directions for use
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the child had any of the following difficulties? If yes, please explain.
Accidents/Fractures _____
High Fever _____
Seizures _____
Food Poisoning _____
Lead Ingestion _____
Bedwetting or Soiling _____
Constipation _____

Vision Problems _____
Hearing Problems _____
Speech Problems _____
Speaking Excessively Loud _____
Memory Problems _____
Allergies _____
Aggressive Behavior _____
Unusual Fears _____
Sleeping Difficulties _____
Head Banging _____
Rocking _____
Temper Tantrums _____
Discipline Problems _____
Other _____

Adolescent Issues
(12-18 years of age)

Have menses begun? No Yes N/A Age of onset _____
Does he/she date? No Yes
Is he/she sexually active? No Yes do not know
Has she been pregnant? No Yes If yes, what was the outcome?_____
Does he/she drive? No Yes
Does he/she work? No Yes Where? _____ Hours per week? _____

Extracurricular Activities?
_____
_____
_____

Does he/she have a group of close friends? No Yes
How does he/she relate to authority?
_____
_____

Does he/she use any of the following?

Drugs No Yes
Alcohol No Yes
Tobacco No Yes

Has he/she ever run away No Yes
If yes, when? _____
Where to? _____
How long? _____

Has he/she ever been hospitalized for emotional problems? No Yes
If yes, what were the circumstances?
_____
_____
_____

Has he/she ever been suspended/expelled from school? No Yes
If yes, when _____
Why?_____
Any legal problems? No Yes
If yes, what were the circumstances?
_____
_____
_____

Any suicidal talk, gestures, or attempts? No Yes
Please describe
_____
_____
_____
_____
_____

Academic History

List schools child has attended

Name of School	City/State	Grade(s)	Problems (if any)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child ever been retained? No Yes
Has your child ever been tested? No Yes
Please list any previous evaluations (i.e. Psychological, Educations, etc.)

Place of Evaluation	Type	Address	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child ever been is a special class placement, received remedial help, or had tutoring? No Yes
If yes, please specify
_____
_____

Relationship With Teachers (please circle one)

Excellent
Average
Poor

Relationship with Peers (please circle one)

Excellent
Average
Poor

Please bring copies of all Psychological, Educational, or other evaluations to your upcoming appointment.

Activities

What things does your child like to do?
_____
_____

What things does your child do well?
_____
_____

What things present difficulty for your child?
_____
_____

Does your child recognize danger situations? No Yes

Give detailed description of an average day:

_____
_____
_____
_____
_____
_____
_____

Other comments:

_____
_____
_____
_____
_____
_____

Symptoms Checklist
(please check yes or no)

Symptom	Yes	No
Difficulty falling asleep		
Trouble remaining sleep		
Loss of Appetite		
Excessive Appetite		
Binge Eating		
Excessive Exercising		
Trouble Concentrating		
Trouble Sitting Still		
Feelings of Sadness		
Tearfulness		
Irritability		
Trouble Controlling Aggression		
Trouble Making Friends		
Trouble with the Law		
Ever been arrested		
Uses drugs		
Uses Alcohol		
Smokes Cigarettes		
Runs away from home		
Hears voices		
Sees visions		
Oppositional to authority		
Gets in fights		
Has been sexually abused		
Sexually molested other children		
Takes medication at this time		

Please elaborate on symptoms marked yes:

_____
_____
_____
_____
_____
_____
_____