

COMMUNITY PSYCHOLOGICAL CONSULTANTS
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An Association of Independent Health Practitioners
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CHILD INFORMATION FORM

Please complete the following form. Use additional paper if necessary to respond to questions or provide additional documentation.

Patient Information:

Full Name _____
Preferred Name: _____ Gender Preference _____
Age _____ Date of Birth _____
Grade _____ School _____

Parent Information:

Name _____ Relationship _____
Address (including zip code) _____

Home or Cell Phone Number (including area code): _____

Occupation _____

Years of Completed Education or Degree _____

Work Phone Number (including area code) _____

Marital Status _____ Number of Marriages _____

If Remarried or Living with Another Adult, Name, Years of Education, and Occupation of Current Partner _____

Name _____ Relationship _____

Address (including zip code) _____

Home or Cell Phone Number (including area code): _____

Occupation _____

Years of Completed Education or Degree _____

Work Phone Number (including area code) _____

Marital Status _____ Number of Marriages _____

If Remarried or Living with Another Adult, Name, Years of Education, and Occupation of Current Partner _____

Presenting Concerns:

Please indicate what specific problems or concerns, if any, related to your child led you to seek evaluation and/or consultation at this time _____

When did you first have these concerns? _____

By seeking evaluation and/or consultation, what changes or outcomes regarding your child do you hope for? _____

Has your child participated in a previous psychological or educational evaluation? When, with whom, and for what reason(s)? What conclusions were reached? Do you feel that these conclusions were valid? Please provide copies of all evaluations. _____

Developmental History:

If your child was adopted, please indicate the age at adoption, describe what you know about your child's life prior to adoption, and answer any additional questions for which you have available information. _____

Briefly describe the pregnancy. Were there any problems or complications during the pregnancy? Was pregnancy with full term? (If not, indicate length of the pregnancy.)

Were any complications noted during labor or delivery? Was this child delivered vaginally or by Cesarean section? (Please describe any complications.)

Child APGAR (if known) _____

Birth Weight _____

Please describe the health of your child at birth, including any complications or need for treatment. _____

Did your child leave the hospital within a normal period of time? (If not, please explain)

Describe your child as an infant (cuddly, difficult, colicky, active, etc.)? _____

At what age did your child:

Smile in response to those around him or her? _____

Roll over from stomach to back? _____

Crawl? _____

Walk without holding on? _____

Use single words? _____

Use two to three word sentences? _____

Remain dry during the day? _____

Remain dry at night? _____

Has your child not attained normal development in any domain? Has your child ever lost previously gained skills? (Please explain.) _____

Please indicate (by checking it) whether your child has evidenced any of the following:

- Problems with Feeding or Eating _____
- Temper Tantrums _____
- Excessive Hitting _____
- Biting _____
- Self-Injurious Behaviors _____
- Social Withdrawal _____
- Rocking _____
- Shyness _____
- Problems with Sleep _____
- Excessive Fears _____
- Excessive Activity Level _____
- Difficulty Sitting Still _____
- Difficulty Paying Attention or Focusing _____
- Difficulty Completing Schoolwork _____
- Disorganization _____
- Repetitive or Compulsive Behaviors _____
- Hand flapping or Toe-walking _____
- Repetitive Vocalizations _____
- Poor Social Skills _____
- Defiance _____
- Lying _____
- Excessive Rule-Breaking _____
- Cutting _____
- Suicidal Thoughts _____
- Suicidal Attempts _____
- Trouble with the Law _____
- Running Away _____
- Truancy _____
- Problems with Drugs or Alcohol _____
- Trauma _____
- Gender concerns _____
- Sexual Molestation or Abuse _____
- Sexual Acting Out _____
- Other _____ (Please indicate below)

If you have checked any of the above behaviors, please explain the behaviors and at what age the behavior was observed _____

Has your child received any early intervention services (speech-language, occupational, physical, developmental, etc.)? If so, please describe the history of these services.

Childcare History:

Please indicate who has cared for your child since birth to the present when you are not home or when your child is not in school. _____

What problems, if any, have been noted in childcare? _____

Educational History:

Please indicate name of school (if different from the previous year) and what problems (if any) were noted, including learning problems, behavioral problems, referral for special services, suspensions or expulsions, retention, or other problems?

Preschool and/or Pre- kindergarten (including age at attendance) _____

Kindergarten (including age at attendance) _____

First Grade _____

Second Grade _____

Third Grade _____

Fourth Grade _____

Fifth Grade _____

Sixth Grade _____

Seventh Grade _____

Eighth Grade _____

Ninth Grade _____

Tenth Grade- _____

Eleventh Grade _____

Twelfth Grade - _____

Has your child ever been retained in a grade? _____

Has your child ever received special education services? _____

If so, for what reason? _____

Has your child ever received tutoring outside of school? _____

Does your child like school? _ _____

Medical History:

Has your child participated in a previous psychological evaluation? When, with whom, and for what reason(s)? _____

Has your child participated in previous counseling? When, with whom, and for what reason (s)? _____

Does your child have any current medical problems? Please explain. _____

Does your child have a history of any medical problems? Please explain. _____

Please indicate what medications, including dosage and time of administration, your child is currently taking on a regular basis, why your child is taking hat medication, and who is the prescriber. _____

Has your child ever been hospitalized? Please explain. _____

Has your child ever had surgery? Please explain. _____

Child's Physician (Name, Address, Phone Number) _____

Has your child's vision been tested recently? Results? _____

Has your child's hearing been tested recently? Results? _____

Has your child been evaluated by an occupational therapist? Results?

Interests:

Does your child participate in any sports activities? Please describe. _____

What are your child's favorite activities, hobbies or interests? _____

Does your child participate in any club or other organization on a regular basis? If so, what clubs or organizations? _____

What special skills or talents does your child have? _____

Extended Family History:

Please indicate (and explain briefly) if any extended family member (blood relation) has or had problems in any of the following areas:

Cognitive Impairment/Mental Retardation: _____

Autism : _____

Learning Disability (problems with reading, writing, spelling, math): _____

Attention Problems: _____

Problems Completing School: _____

Behavior Problems: _____

Strong Temper: _____

Anxiety or Worry: _____

Shyness: _____

Obsessions or Compulsions: _____

Panic Attacks: _____

Excessive Fears or Phobias: _____

Depression: _____

Bipolar or Cyclical Depression: _____

Suicide (attempts or completed suicide): _____

Hallucinations or Delusions: _____

Alcohol or Drug Problems: _____

Trouble with the Law: _____

Other: _____

What family stressors may impact (or have impacted) on your child's current functioning. Please explain. _____

Any Additional Information:

Please provide any additional information that may be helpful in understanding your child's needs. _____

Name of Person Completing This Form _____

Date of Form Completion _____