Patient Name _____DOB_____

Child and Family Information Assessment Form

Gender: M F Age: _____ Birth date:_____Ethnic identification: _____Year in school_____
Child's current residence: __With biological parents__ Other: If "other," please explain:_____
Who has legal custody of the child?_____

Presenting problem(s):_____
_____
_____
_____

Social History
Parents' Marital History/Current History:__Married: __Separated:__Divorced:__Remarried:__Other:
Family and Home Information
All persons currently living in the household:

Name	Birth date	Sex	Education level	Relationship

Has the child lived with both parents since birth? No Yes
If "no," list changes chronologically (include residential placements).
From: To: Child lived with:
(Dates preferred, or child's ages).
_____
_____
_____

If child is not living with both parents, please list reason:
__ Parents separated__Parents divorced__ Parent deceased__ Other__If "other," please explain:

If the child has a parent not living with the child, are there visitations?
No Reason:_____
Yes How frequently_____
If there are any other children living in the family:_____

Is your house troubled by domestic violence?__No__Yes
If "yes," please explain:_____
Is your child had/has been suffered from abuse or other psychological trauma?__No__Yes
If "yes," please explain:_____

Child's Developmental and Medical History
Were there any prenatal problems during pregnancy?__No__ Yes
If "yes," please explain:_____

Were there any problems during delivery?__No__Yes

If "yes," please explain: _____
Birth weight: lbs oz.
Infancy:

A. Were there any feeding problems?__No__Yes
If "yes," please explain: _____

B. Did your child sleep well?__No__Yes
If "no," please explain:_____

C. At what age was your child toilet trained?_____Were there any difficulties?

Milestones

At what age did your child:

Wean Walk Sit up alone Talk

Were there any difficulties? _____

Are there any problems with bedwetting/accidents?__No__ Yes

Night Frequency

Daytime accidents Frequency

Please indicate age of child at the time of illness:

Chickenpox	Mumps
Diphtheria	German measles
Red measles	Poliomyelitis
Rheumatic fever	Scarlet fever
Tuberculosis	Whooping cough
Pneumonia	Other

If "other," please explain: _____

Does or did your child ever have severe ear infections?__No__Yes
Does or did your child have allergies?__No__Yes
If "yes," to what does the child have allergies? _____
How severe are the reactions?_____
Are there any special precautions that need to be taken? _____
Does or did your child have lead poisoning?__No __Yes
If "yes," please explain:_____

Please detail any of your child's hospitalizations:

Date Age Hospital Reason Length of stay

_____
_____
_____

Please detail any medication history:

Date Age Drug Reason Physician

_____
_____
_____
_____

Family History

Does anyone in the family have physical or emotional problems?__No__ Yes
If "yes," please explain:_____

If "yes," have they received counseling or other forms of help?__No__Yes
If "yes," please explain:_____

Is there a history of any of the following in the family?
(Use "M" for mother's side; "F" for father's side.)

TB	Vision problems
Birth defects	Hearing problems
Emotional problems	Drugs
Behavior problems	Alcohol
Mental retardation	Diabetes
Goiter (Thyroid)	Convulsions/seizures
Other	

If "other," please explain:_____

Agency Involvement/Service/ Treatment History

Please include (chronologically if possible) as complete a history as possible. Include agencies, physicians, counselors, institutions, therapists, etc.

Date Age Contact person Services provided Length of involvement

_____
_____
_____
_____
_____
_____

Has your child been court involved?__No__Yes
If "yes," please explain:_____

Child's School History

School attendance:

Date Location Problems (Y/N) Reason for leaving

Preschool_____
Kindergarten_____
Grade 1_____
2_____
3_____
4_____
5_____
6_____
7_____
8_____
9_____
10_____
11_____
12_____

If answered "yes," to problems at any academic level, please detail here. Please give any information about treatment (if any) provided by the school at the time of occurrence:_____

Typical Day Descriptions

A. On a school day, how does the child awaken? (by himself, by you, etc.)

B. How does your child prepare himself for the day? (Who selects clothing, etc.?)

C. Does the child ready himself quickly or require continual reminding?

D. Does the child eat breakfast? No Yes If so, who prepares it?

E. Does the child watch the time and leave promptly or is frequent reminding necessary?

F. Does the child watch the time or is frequent reminding necessary?
No Yes

G. What does the child do after school?

H. What occurs at dinnertime?

1. Does the family eat together? No Yes
2. Is the child on time? No Yes
3. Are there any problems during dinner? No Yes
4. Does he/she participate in family conversations during meals? No Yes

If you answered "no," to any or these questions, or "yes," to question 3 please explain:

I. What occurs after dinner?

J. What happens at bedtime?

K. What does the child do on weekends?

L. Does your family have much "family time" together (shopping, movies, etc.)?

M. What activity do you enjoy most with your child?

N. Does you child spend time with friends?
How much time on a weekly basis?
How many friends does you child have?
How do you feel about your child's friends?

O. Does your child belong to any clubs, groups, or organizations?
If so, which ones:

P. Does you child have any interests or hobbies?

Q. Does you child get an allowance? No Yes
If so, is it earned or given?
How does the child manage the money?

R. Does your child have specific chores? No Yes
Does you child try to avoid doing chores? No Yes
What does he do to try to avoid them (refuse, argue, etc.)?

S. What methods do you use to discipline your child?
How often is it necessary? Does it work?

Behavior Checklist

Check the behaviors listed below that apply to your child within the past 6 months.

- Makes no sounds.
- Makes sounds but says no words.
- Says a few words (specify:).
- Speaks well but was slow in developing speech.

- Repeats words over and over.
- Was speaking but is no longer.
- Is clumsy and awkward.
- Is often drowsy.
- Displays stereotypic behaviors (for example: wave hands in front of face, stares blankly, etc.)

If so, which ones:

- Engages in self-destructive behaviors:
  hair pulling self-biting self-pinching head banging
  other (please specify):
- Has tantrums frequently.
- Is hyperactive.
- Seldom makes eye contact.
- Demands too much attention.
- Is often sluggish or slow moving.
- Often has physical complaints (i.e., headaches, stomachaches, etc.).
- Usually plays alone.
- Disobedience, difficulty with disciplinary control.
- Asks for help when it is not needed.
- Gives up easily.
- Does not interact appropriately with:
  Parents Siblings Peers Others
- Physically abuses:
  Parents Siblings Peers Pets Toys
- Cries, whines, or pouts frequently.
- Unreasonable noise, yelling.
- Does not play with toys.
- Rarely obeys requests, commands, etc.
- Talks back to parents or other authority figures.
- Reacts poorly when losing a game.
- Unreasonable fears (heights, animals, the dark, etc.) Please specify:
- Does not recognize danger.
- Runs away frequently.
- Does not observe curfew.
- Will not play alone.
- Problems at mealtimes (disruptive, selective about foods).
- Has a sleeping problem.
- Cannot feed self.
- Cannot dress self.
- Is not toilet trained.
- Is toilet trained but: wet pants, soils pants, wets bed.

- Frequent lying.
- Sets fires.
- Steals.
- Seems to have a hearing problem.
- Seems to have a vision problem.
- Other physical handicap (specify:).
- Negative comments to:
  Parents Siblings Peers Others
- Teasing of:

Parents Siblings Peers Others

- Complaining.
- Wanders off.
- Sadness.
- Complaints from neighbors.
- Police contact.
- School contact.

Please describe other problems:

_____
_____
_____

What behavior distresses you the most?

_____
_____
_____

What do you think are your child's greatest strengths?

_____
_____
_____
_____

Please describe the changes you hope to see in your child as a result of our work:

_____
_____
_____
_____
_____