



CHILD AND FAMILY INFORMATION ASSESSMENT FORM

Today's Date: _____

This information supplied by (name and relationship to patient) _____

Reason(s) for this visit: _____

CHILD'S DEMOGRAPHICS

Child's full legal name: _____

Current Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Preferred nickname: _____ Height: _____ Weight: _____

Birth Date: _____ Age: _____ Gender: Male or Female

Ethnic Identification: _____ Year in School: _____

Living with biological parents: Y or N or Other (relationship): _____

PARENT'S DEMOGRAPHICS

Biological Father's full legal name: _____

Birth Date: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Married: Y or N If Yes, To (full name): _____

Separated: Y or N If Yes, From (full name): _____

Divorced: Y or N If Yes, From (full name): _____

Biological Mother's full legal name: _____

Birth Date: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Married: Y or N If Yes, To (full name): _____

Separated: Y or N If Yes, From (full name): _____

Divorced: Y or N If Yes, From (full name): _____

ALTERNATIVE CONTACTS

Emergency Contact: _____

Telephone Number: _____ Relationship: _____

FAMILY AND HOME INFORMATION

All persons currently living in the household and siblings:

Name	Birth Date	Gender	Living in House	Relationship
_____	____/____/____	____	_____	_____
_____	____/____/____	____	_____	_____
_____	____/____/____	____	_____	_____
_____	____/____/____	____	_____	_____
_____	____/____/____	____	_____	_____
_____	____/____/____	____	_____	_____
_____	____/____/____	____	_____	_____

If child has not always lived with parents since birth, with whom has she/he lived? (list changes/moves in chronological order).

Child lived with:	From(age)	To	Reason for move
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If the child has a parent not living with the child, are there visitations?

Yes ____ How frequently: _____

No ____ Reason: _____

Is your house troubled by domestic violence? Y or N

If yes, please explain: _____

CHILD'S DEVELOPMENTAL HISTORY

Mom's age at time of pregnancy: ____ Prenatal care started at ____ months pregnant

Planned Pregnancy? Y or N Were there any problems during pregnancy? Y or N if yes please explain: _____

Birth weight: ____lbs____oz Apgars: _____

Did Mom take any medications during pregnancy: Y or N If yes, what? _____

Smoke cigarettes? Y or N

Did Mom use alcohol or drugs during pregnancy? Y or N

Where there any feeding problems with the child? _____

Describe child's temperament as an infant and toddler: _____

At what age did child: smile _____ crawl _____ sit alone _____ walk _____ talk _____ toilet train _____

Where there any concerns expressed by the doctor about development? Y or N If yes, please explain: _____

Are there any problems with bedwetting? Y or N If yes,

Night: Y or N Frequency _____

Daytime: Y or N Frequency _____

CHILD'S MEDICAL HISTORY

Family Doctor Name: _____ Phone number: _____

Current medications: _____

Medication allergies: _____

List any hospitalizations: _____

List any surgery: _____

List any childhood illness: _____

Child had any seizures? _____

Any head trauma? _____

Exposure to lead or other toxins? _____

To your knowledge, are all of the immunizations up to date: Yes No (if no, explain) _____

FAMILY MEDICAL HISTORY

Is there any history of the following in the family? (use **M** for mother's side; **F** for father's side or **B** for both sides).

Please identify family member (uncle, aunt, grandparent, etc).

MFB	Relationship	MFB	Relationship
_____	Tuberculosis	_____	Birth Defects
_____	Blood Pressure	_____	Tics
_____	Neurological	_____	Diabetes
_____	Mental retardation	_____	Heart
_____	Convulsions/seizures	_____	Thyroid
_____	Other If other, please explain: _____		

FAMILY PSYCHIATRIC HISTORY

MFB	Relationship	MFB	Relationship
<input type="checkbox"/> Eating Disorder	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Anxiety Disorder	_____	<input type="checkbox"/> Suicide	_____
<input type="checkbox"/> Developmental delays	_____	<input type="checkbox"/> Abuse	_____
<input type="checkbox"/> Obsessive/Compulsive	_____	<input type="checkbox"/> PTSD	_____
<input type="checkbox"/> Learning disability	_____	<input type="checkbox"/> ADHD	_____
<input type="checkbox"/> Alcohol problems	_____	<input type="checkbox"/> Drug Problem	_____
<input type="checkbox"/> Bipolar disorder	_____	<input type="checkbox"/> Legal Problem	_____
<input type="checkbox"/> Psychotic/Schizophrenia	_____	<input type="checkbox"/> Panic Attacks	_____
<input type="checkbox"/> Psychiatric	_____	<input type="checkbox"/> Other	_____

If other, please describe: _____

Please list any psychiatric hospitalizations for child and state reason and length of stay. _____

Please list any prior counseling/therapy for child, reason why and length of therapy. _____

Please list any prior psychiatric medications child has taken, reason why, and reason discontinued. _____

Has child been court involved? Y or N If yes, please explain: _____

CHILD'S EDUCATION HISTORY

List school(s) child has attended grades preschool through 12, and reasons for changing schools.

School	Grades	Reason for changing
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has child had an IEP? Y or N When? _____

Has the expressed concern about their own academic ability or behavior? Y or N

TYPICAL DAY DESCRIPTIONS

Does the child require continual reminding to get ready for some activity (school/homework...etc) ? Yes or No

Does the child eat breakfast? Yes or No If so, who prepares it? _____

What does the child do after school? _____

What occurs at dinnertime:

1. Does the family eat together? Y or N
2. Is the child's behavior appropriate during dinner? Y or N
3. Does she/he participate in family conversations during meals? Y or N

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

What occurs after dinner? _____

What happens at bedtime? _____

What activities does the child do on the weekends? _____

What activity do you enjoy most with the child? _____

Does child spend time with friends? Y or N How often? _____

How do you feel about child's friends? _____

What clubs, organizations, teams, etc is child involved with? _____

What interests or hobbies does child have? _____

Does child get an allowance? Y or N Does child participate with chores? Y or N

How do you discipline the child? _____

BEHAVIOR CHECKLIST: Check the behaviors listed below that apply to child within the PAST SIX (6) MONTHS

- ____ Repeats words over and over
- ____ Is clumsy and awkward
- ____ Is often drowsy or tired
- ____ Displays stereotypic behaviors (for example, waves hands in front of face, stares blankly, etc) If so which ones: _____
- ____ Has tantrums frequently
- ____ Is hyperactive

- ☐ Seldom makes eye contact
- ☐ Demands too much attention
- ☐ Is often sluggish or slow moving
- ☐ Often has physical complaints (for example, 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, ☐ furniture
- ☐ Cries, whines or pouts frequently
- ☐ Rarely obeys requests, commands, etc.
- ☐ Talks back to parents or other authority figures
- ☐ Unreasonable fears (heights, animals, the dark, etc.) Please specify: _____
- ☐ Does not recognize danger
- ☐ Will not play alone
- ☐ Has a sleeping problem
- ☐ Frequent lying
- ☐ Sets fires
- ☐ Steals
- ☐ Seems to have hearing problems
- ☐ Negative comments to ☐ parents, ☐ siblings, ☐ peers, ☐ others: _____
- ☐ Testing of ☐ parents, ☐ siblings, ☐ peers, ☐ others: _____
- ☐ Wanders off
- ☐ Complaints from neighbors
- ☐ Police 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 the child as a result of our work: _____
