ALPHA PSYCHOLOGICAL SERVICES, P.C.
CHILD HISTORY FORM

The following questions are asked so we can best understand your child. Please fill out this form before the child is evaluated. Please read the questions and carefully answer them as fully as possible. Use the back of the sheet if necessary. If unsure of a question, please review it with the doctor at the time of your appointment.

Child's Name_____

Birthdate_____Age_____Sex_____

Home street address_____

City_____State_____Zipcode_____

Parent:_____ Home
phone_____Cell_____

Work phone_____Email_____
Is it OK to leave messages: (yes or no) ____home; _____work; _____cell; _____email

Reason for seeking help for your child at this time?

Mother_____Age_____
Address (if different from above)
_____
Phones (if different from above)
_____

Place of employment:_____
Occupation_____

Father_____Age_____
Address (if different from above)
_____
Phones (if different from above)
_____

Place of employment:_____
Occupation_____
Child is living with: _____both parents; _____mother; _____father; _____legal guardian; _____father and stepmother; _____mother and stepfather; _____other

If the parents are divorced, date_____

If mother remarried (or living with a partner), date_____
name of spouse (partner)_____

If father remarried (or living with a partner), date_____
name of spouse (partner)_____

What is the custody arrangement?

Were parents married previously before child's birth? ____yes; _____no
Dates: Parent_____from_____to_____
Dates: Parent_____from_____to_____
Is either parent deceased? Year_____

Is the child adopted?_____ Child's age at adoption_____
Adopted from a country other than US?_____
Child's race_____Ethnic/cultural_____
Family's religion?_____Actively involved?_____
Does child participate in religious programs/activities?_____

PREGNANCY HISTORY
Any medications taken by the mother during pregnancy?_____
Did the mother use any of these during pregnancy:
___cigarettes (per day____); _____alcohol (type_____, per day_____);
drugs (type_____, per day/week/month_____)
Was the father taking any medications or drugs at the time of conception?_____
If yes, what?

Birth weight_____Was the child in Neonatal Intensive Care?___yes _____no
If yes, please describe:

Was the pregnancy (please answer yes or no):
Planned?_____Normal?_____Was the mother ill?_____Was the pregnancy easy?_____ Was the baby premature?_____(length of gestation_____)
Delivered: _____spontaneous, _____forceps, _____caesarean, _____feet first, _____head first, _____blood transfusion, _____X-Ray, _____EEG

INFANCY
In the first 2 weeks of life, please indicate Yes, No, or "U" (Unknown):
Yellow appearance_____ Blue lips_____ Vomiting_____
Difficulty breathing_____ Feeding difficulty _____ Irritable_____
High fever_____ Slow responding_____
Convulsions/Twitching_____
Any physical deformities or disabilities?

Was the child breast fed?_____(if yes, until what age?_____), Did the infant feed well?_____ (if no, explain), Weight gain normal?_____(if no, explain)

Indicate age of child when:
Stood alone_____ walked alone_____ used words_____ spoke sentences_____
potty trained_____ bowel trained_____

EARLY CHILDHOOD
Check any or all of the following conditions:

vomiting_____	thyroid_____	diabetes_____	seizures_____
diarrhea_____	constipation_____	colic_____	headaches_____
chest pains_____	asthma_____	fevers_____	
high blood pressure_____	blood sugar irregularities_____		trouble sleeping_____
nightmares_____			

others:

Is the child's sleep generally: Good_____ Fair_____ Poor_____ Irregular_____
Does the child have allergies? If yes, please list:
Please rate the child on the following behaviors. 1=majority of the time; 5=seldom, and stages in between 2-4.

quiet, content	1	2	3	4	5	colicky and irritable
easy to feed	1	2	3	4	5	daily feeding problems
slept well	1	2	3	4	5	frequent sleep problems
usually relaxed	1	2	3	4	5	often restless
under active	1	2	3	4	5	over active
cuddly, easy to hold	1	2	3	4	5	did not enjoy cuddling
easily calmed down	1	2	3	4	5	tantrums or headbanging
cautious, careful	1	2	3	4	5	accident prone, risky
coordinated	1	2	3	4	5	uncoordinated
enjoyed eye contact	1	2	3	4	5	avoided eye contact
liked people	1	2	3	4	5	disliked contact with people
adventurous, curious	1	2	3	4	5	shy, avoidant

Did any event, health condition, separation, death in the family, etc., disturb early infant/mother or infant/father bonding? If yes, please explain:

Any additional information about the child's conception and birth?

FAMILY
Siblings at home with the child:

Name	Age	Sex	Grade	School

Any social, behavioral or health problems with the siblings:

Any miscarriages or siblings who are deceased? Sex_____Year_____

Others living in the child's home (note full or part-time):

Has the child lived in any other home? Dates_____with_____

Other siblings not living in the child's home:

Does the child's family have financial problems? _____yes _____no
Has the child ever been physically or sexually abused? _____yes _____no
Has the child ever physically or sexually abused anyone? _____yes _____no

MEDICAL (Any "yes" answers, please use back of page to explain)
Has the child ever sustained any physical injuries? _____yes _____no
Has the child had regular immunizations? _____yes _____no
Has the child ever had a Head Injury? _____yes _____no
If yes, lost consciousness? How long?
Has the child ever been hospitalized? ____yes ____no
If yes, please explain: (event, age, condition, outcome)
Has the child ever been taken to an emergency room? ____yes _____no

Check problems that apply to the child:
_____speech/language _____hearing _____vision
_____motor coordination _____disability/handicap
_____learning _____social _____emotional
_____eating (over eating, under eating) _____sleep
_____relationships _____daily structure _____disorganization
_____discipline _____addictions
_____attempted suicide or suicidal ideations _____homicidal attempts or ideations, _____anger _____attention deficit or hyperactivity
_____other

List all medications (prescription or street drugs or over the counter), alcohol, drugs the child takes or has taken (list name, dosage and dates taken):

Who is the child's current physician(s):_____
Address_____
Phone_____
(If additional specialists, use back of sheet)
When was the last exam? _____for_____

PARENTS AND EXTENDED FAMILY

Father	Mother
Education_____	Education_____
Born in US?_____	Born in US?_____

With the parents or extended family, any learning difficulty history, grade level it occurred, attention-deficit disorder or hyperactivity, any psychological or psychiatric problems for which treatment was received?

Any parental or extended family with problems with drugs or alcohol:

Please provide any further information about the child's extended family (grandparents, uncles, aunts, cousins) that might help us understand the child's needs and history:

EDUCATION

Did the child attend pre-school or daycare? _____yes _____no
Any particular problems that occurred during that time?

List schools attended prior to current time:

Current
school_____Grade_____

Teacher(s)_____
Subjects Grades
_____
_____
_____
_____
_____

Please use the back of the page to explain any of the following "yes" answers
Are current grades any different from previous years? _____yes _____no
Is the child in a special program? _____yes _____no
Has the child been in a special program previously? _____yes _____no
Has the child needed tutoring? _____yes _____no
Has the child been a behavior problem at school ____yes ____no
Does the child engage in extra-curricular activities? _____yes _____no

HOME

How many friends does the child have?
What types of activities do they engage in?

How does the child spend leisure time (inside activities, outside activities)?

Is there a computer in the home? _____yes _____no
Is there one in the child's bedroom? _____yes _____no

Do you set restrictions on computer use? _____yes _____no
How do you monitor the computer use?

Does the child have regular home duties?

Has the child ever been involved with the police/courts? _____yes _____no
How many hours per day does the child watch TV?
School days_____ Weekends_____ Summers/days off_____
Favorite programs?

Does your child have a television in his/her bedroom? _____yes _____no
Does your child own a bike helmet? _____yes _____no Uses it? ____yes ____no
Does the family eat meals together? Breakfast _____yes _____no
Dinner _____yes _____no
Does the family have social discussions during meals? _____yes _____no
Does your child awaken in the morning and go about a dressing/cleaning up/eating routine fairly regularly without a lot of prompting? _____yes _____no
What are some activities the family engages in together?

Any other information you feel is important, please elaborate on the back of this page.

_____ _____
Signature of parent/guardian supplying this information Date