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CHILD INFORMATION FORM

CHILD'S NAME: _______________________________________DOB:______________Age:__________

BIRTH AND DEVELOPMENT

Did you have or use any of the following during your pregnancy with this child?

	Yes	No	If yes, please describe:
Medical illness			
Medication			
Drugs			
Alcohol/Cigarettes			
Trauma			
Complications during delivery			
Problems after birth			
Other:			

DEVELOPMENTAL HISTORY

Please indicate the age when your child achieved each of the following developmental milestones:

	Age
Sat without assistance	
Walked alone	
Said his/her first words	
Completed urinary/bowel training	
Stopped wetting the bed	

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Has your child ever had any of the following?

	Yes	No	If yes, please describe (include age when started/ended):
Unusual behaviors			
Difficult to manage			
Unusual fears			
Developmental difficulties			
Speech problems			
Coordination problems			
Multiple caretakers			
Major losses/traumas			
Difficulties in school			
Frequent school changes			
Other:			

MEDICAL HISTORY

Date of Last Physical Exam:________________________________Doctor:_____________________________

Address:____Phone:_____________________________

Known drug allergies/Adverse reactions:____

Current Medical Problems:____

____

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Current Medications: Yes No *(If no, skip to past medical history)*

Medication	Dose	Frequency

Past Medical History: Yes No (*If no, skip to nutritional concerns)*
(Please include any health problems, significant illnesses, recurrent ear infections, hospitalizations, surgeries, accidents, head traumas, loss of consciousness, lead poisoning, etc.)

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Nutritional Concerns: Child's current weight: ___________pounds

Please indicate if you have noticed any of the following regarding your child's eating habits:

	Yes	No	If yes, please describe:
Weight changes			
Appetite changes			
Excessive eating			
Peculiar eating habits			
Does your child make him/ herself throw up			
Other:			

Sleep Assessment:

Please indicate if you have noticed any of the following regarding your child's sleep habits:

	Yes	No	If yes, please describe:
Changes in your child's sleep habits?			
Excessive sleeping?			
Difficulties falling asleep?			
Waking up multiple times during the night?			
Nightmares?			
Bedwetting?			
Other:			

FAMILY CULTURAL/SPIRITUAL IDENTITY

What is your family's cultural identity?____

Describe any significant religious beliefs, practices or experiences:______________________________

____

Child's country of birth:___________________ In the USA for ___________________________years.

Mother's country of birth:__________________ In the USA for ___________________________years.

Father's country of birth:___________________ In the USA for ___________________________years.

What language is spoken at home?_______________________________________

What language does the child understand best?_______________________*Speak* best?_____________________

How does this family manage anger? Describe:____

____

Please describe your child's positive character traits (Give examples):__________________________________

____

What kind of disciplinary measures are used in this family?____________________________________

____

Please identify areas you consider to be family strengths_____________________________________

____

Are you interested in parenting skills training? Yes No If yes, what areas do you believe need more

emphasis? ____

____

FAMILY DATA

Name	Marital Status	Highest Grade Completed	Occupation
Mother			
Father			
Other (Primary Caregiver)			

Family Composition: *(List each member of the family who lives with the child. Include mother/step-mother, father/step-father, guardian, other children, relatives, friends, etc.)*

Name	Age	Relationship to child

Family psychiatric and medical history*: *(Include all first degree relatives)*
**Do not disclose any information to child unless you have permission from the parents.*

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	Psychiatric	Drugs/Alcohol	Medical
Mother			
Father			
Siblings			
Other			

Is there anything else you would like us to know about your child? ____________________________________

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