

Child and Family Information Form
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Please fill out the following form. This information will assist us in providing a holistic and comprehensive assessment and treatment planning for your child.

Child's Name _____ Age: _____ Date of Birth: _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone: _____ Dad Mom (Circle One)

Father's Name: _____ Age: _____ Education: _____ (yrs)

Father's Place of Employment: _____

Mother's Name: _____ Age: _____ Education: _____ (yrs)

Mother's Place of Employment: _____

Are parents married? ☐ Yes ☐ No Separated?: ☐ Yes ☐ No Divorced?: ☐ Yes ☐ No

Custody? ☐ Joint ☐ Mom ☐ Dad

Relationship to child: ☐ Biological ☐ Adopted ☐ Step ☐ Foster ☐ Other

Current Household

Name/Relationship Age

| | |
|--|--|
| | |
| | |
| | |
| | |
| | |

Significant Family not living with Child?

Name/Relationship Age

| | |
|--|--|
| | |
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| | |

Has anyone close to your child died?

Relationship to child

Child's age at time

Cause of Death

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School

Name of School: _____

Grade: _____

Has your child ever been held back in school? ☐ Yes ☐ No

Education Service? ☐ Yes ☐ No (Check): ☐ Accelerated/Honors ☐ IEP ☐ 504 ☐ OT ☐ Speech

Resource/what subjects? _____

School social worker or **school** counselor? ☐ Yes ☐ No Name: _____

Absenteeism/Detentions/Suspensions? ☐ Yes ☐ No

Please explain: _____

Developmental and Medical Information

Pregnancy and Delivery

Length of Pregnancy _____ Length of delivery/labor _____ Mother's age _____

Child's birth weight _____ Labor (Check): ☐ Induced ☐ Cesarean ☐ Forceps ☐ Breech ☐ Medication

Pregnancy (check): ☐ Bleeding ☐ Toxemia/eclampsia ☐ Serious injury/illness ☐ Prescription medication

Cigarettes # _____ Illegal Drugs _____ Alcoholic beverages # _____

Did any of the following conditions affect your child during delivery or within the first few days after birth?

(check all that apply) ☐ Injury at birth ☐ Cardiopulmonary distress during delivery ☐ Cord around neck

☐ Cyanotic/blue ☐ Jaundiced/yellow ☐ Infection ☐ Seizures

☐ Medications ☐ Congenital Defect ☐ Hospitalized

Infant Health and Treatment

During the first 12 months, was your child (check all appropriate):

☐ Difficult to feed ☐ Difficult to go to sleep ☐ Colicky ☐ Difficult to put on a schedule

☐ Alert ☐ Cheerful ☐ Easy to comfort ☐ Sociable ☐ Difficult to keep busy

☐ Affectionate ☐ Overactive/constant motion ☐ Very stubborn/challenging

Early Developmental Milestones

As a small child, did your child have serious difficulty with (check all appropriate):

- ☐ Learning to walk/talk ☐ Going to school ☐ Making friends/playing with others
- ☐ Crying whenever parent/guardian left ☐ Experienced unusual fears
- ☐ Exposure to a traumatic or serious event

Medical History

Last physical exam: _____

| <u>Specialty Doctors/Clinics</u> | <u>Age</u> | <u>Reason</u> | <u>Location</u> |
|----------------------------------|------------|---------------|-----------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please check if your child has experienced any of the following problems:

- ☐ Asthma ☐ Allergies ☐ Arthritis ☐ Chronic Illness ☐ Allergies ☐ Diabetes ☐ Seizure Disorder
- ☐ Febrile Seizures ☐ Heart/blood pressure problems ☐ Head Injury ☐ Lead Poisoning
- ☐ Loss of Consciousness ☐ Chronic Ear Infections ☐ Strep Infections ☐ Surgery
- ☐ Hospitalizations (medical/psychiatric) ☐ Visual/Hearing problems ☐ Gross/Fine Motor problems
- ☐ Appetite problems (overeating/under eating) ☐ Soiling/wetting problems ☐ Emotional abuse
- ☐ Physical abuse ☐ Neglect ☐ Sexual Abuse ☐ Witness to violence
- ☐ Sleep problems (falling asleep, staying asleep, nightmares, night terrors)

Any other medical problems? _____

Medications currently taking, including over the counter

| Medication Name | Reason for taking |
|-----------------|-------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please list family member's significant medical history:

Psychiatric History

Has any paternal/maternal family member (parents, siblings, grandparents, aunts, uncles) experienced problems with:

- ☐ADHD ☐Alcohol ☐Anxiety ☐Autism ☐Bipolar Disorder ☐Depression ☐Domestic Violence
☐Drugs ☐Learning Disorders ☐Problems with the Law ☐Self-Harm ☐Suicide/Suicidal Thoughts

Please explain: _____

Has your child ever seen a counselor? ☐Yes ☐No

Name: _____ Address: _____

Please check areas of concern:

- ☐Unduly sad ☐Overly anxious ☐Unusual fears ☐Suicidal thoughts ☐Self harming behaviors
☐Overly aggressive ☐Temper tantrums ☐Withdrawn or shy ☐Disturbing habits/mannerisms
☐Strange/bizarre behaviors ☐Academic problems ☐Problems with peer relationships ☐Drug/alcohol problems
☐Problems with family relationships ☐Difficulty with authority ☐Behavior problems ☐Fire setting
☐Sexual activity ☐Attendance problems ☐Learning disabilities ☐Attention problems ☐Abuse

Other concerns: _____

Please list 3 things about your child you feel are special

1. _____
2. _____
3. _____

Please list child's hobbies

1. _____
2. _____
3. _____

Confidential Fact Sheet for Children and Adolescents

This form is to be completed by the legal parent or guardian of the child/adolescent.

Child's Name _____ Date of Birth: _____

Address _____

Phone: _____ Emergency Contact & Phone# _____

PART I: Description of Problems – (in my own words)–Why Child/Teenager is here - Following Problems

| Part II: The Child/Teenager | Never | Sometimes | Often |
|--|-------|-----------|-------|
| 1. Complains of aches or pains | | | |
| 2. Spends more time alone | | | |
| 3. Tires easily, little energy | | | |
| 4. Fidgety, unable to sit still | | | |
| 5. Has trouble with teacher | | | |
| 6. Acts as if driven by a motor | | | |
| 7. Daydreams too much | | | |
| 8. Distracted easily | | | |
| 9. Is afraid of new situations | | | |
| 10. Feel sad, unhappy | | | |
| 11. Is irritable, angry | | | |
| 12. Feels hopeless | | | |
| 13. Has trouble concentrating | | | |
| 14. Less interest in friends | | | |
| 15. Fights with other children | | | |
| 16. Absent from school | | | |
| 17. School grades dropping | | | |
| 18. Is down on himself or herself | | | |
| 19. Visits physician, but physician finds nothing wrong | | | |
| 20. Has trouble sleeping | | | |
| 21. Has nightmares | | | |
| 22. Worries a lot | | | |
| 23. Want to be with parents more than before | | | |
| 24. Feels he or she is bad | | | |
| 25. Takes unnecessary risks | | | |
| 26. Gets hurt frequently | | | |
| 27. Seems to be having less fun | | | |
| 28. Acts younger than children his or her own age | | | |
| 29. Does not listen to rules | | | |
| 30. Does not show feelings | | | |
| 31. Does not understand other peoples feelings | | | |
| 32. Teases others | | | |
| 33. Blames other for his or her troubles | | | |
| 34. Takes things that do not belong to him or her | | | |
| 35. Refuses to share | | | |
| 36. Has trouble with eating or weight gain/loss | | | |
| 37. Expresses thought of killing himself/herself | | | |
| 38. Physically hurts self (cutting, burning, head banging) | | | |
| 39. Physically aggressive towards others | | | |