North Oakland Family Counseling Center

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Instructions To provide greater understanding of your concerns please fill in the blanks or check the correct answers. Please answer as thoughtfully and frankly as possible, since this information will provide some direction on how we might address your concerns. All information is regarded as confidential. If you have difficulty with any of the questions, please leave them blank for now. Thank you for taking time to complete this form.

Name of Child_____
Address_____Phone_____
D.O.B:_____ Information provided by_____
Parent/Guardian Information:
Mother/Female Guardian name:_____ Father/Male Guardian name:_____

What are your primary concerns?

_____

_____

_____

_____

What questions would you like answered?

_____

_____

_____

_____

How long have these problems been occurring?_____

_____

Have there been any significant changes or stressors in your child's life during the last year?

_____

_____

_____

_____

Physician Information

Pediatrician: _____ Phone: _____
Other physicians (other medical specialists):
Physician: _____ Phone: _____

Family History

Immediate Family:

Please complete the following:

Relationship	*Name/Age*	*Education/Occupation*	*Special Problems*	*Living with Child*
Parent/Guardian (Circle one)				☐Yes ☐No
Parent/Guardian (Circle one)				☐Yes ☐No
Sibling				☐Yes ☐No
Sibling				☐Yes ☐No
Sibling				☐Yes ☐No
Sibling				☐Yes ☐No
Other/specify				☐Yes ☐No
Other/Specify				☐Yes ☐No

If parents are married, what year did they marry?_____

If separated or divorced, provide date:_____

Has either parent remarried? If yes, please describe:_____

_____

Newborn History

General information:

Gender: ☐Male ☐Female ☐Other Is the child adopted? ☐Yes ☐No _____age of adoption

Who has legal custody of the child? _____

Where was the child born (hospital, city-state) _____

Was the child born: Early by 1 week or more-if yes, how early? _____ ☐Full Term

Overdue one week or more ☐Yes ☐No If yes, how overdue? _____

Was the child born by: ☐Normal delivery ☐Breech (feet first) ☐Caesarian section

If C-section: ☐Planned ☐Emergency

Pregnancy/Birth Information:

Were there any problems or complications during pregnancy or delivery? ☐Yes ☐No

Check any of the following that apply:

☐Accident ☐Anemia ☐Preeclampsia, eclampsia, or toxemia
☐Bleeding ☐Diabetes ☐High Blood pressure
☐Illness ☐Surgery ☐Psychological problems or stress
☐Fetal distress ☐Excess vomiting ☐Premature placenta separation

Did the mother take medications or have an X-ray during pregnancy? ☐Yes ☐No

Did the mother drink alcohol during pregnancy? ☐Yes ☐No

How much: _____ How Often: _____

Did the mother use cocaine or any other drugs during pregnancy? ☐Yes ☐No

Did the mother smoke cigarettes during the pregnancy? ☐Yes ☐No

Was labor induced with the child's birth? ☐Yes ☐No

If yes, with:_____

Was mother given medication/hospitalized to stop premature deliver? ☐Yes ☐No

Was the mother in labor with the child over 24 hours? ☐Yes ☐No

Did the mother's water break over 24 hours before delivery? ☐Yes ☐No
Did the mother have any postpartum complications? ☐Yes ☐No
How many pregnancies has this child's mother had?_____
Were there any miscarriages? ☐Yes ☐No How many? _____
Were there any stillbirths? ☐Yes ☐No How many? _____
What was the child's birth weight? _____Lbs. _____oz.
How often did the mother see the doctor during her pregnancy with this child? _____
How much time passed before the mother realized she was pregnant? _____Weeks.
At what age did the child first leave the hospital?_____
Initial Complications: ☐ Jaundice ☐ Respiratory problems ☐ Other ☐
Treatment_____

Infant Problems:
As an infant, did the child have any of the following problems? Check those that apply.

☐Feeding trouble	☐Colic	☐Excess Vomiting
☐Constipation	☐Blueness (cyanosis)	☐Seizure(convulsions)
☐Need for oxygen	☐Breathing trouble	☐Yellow Jaundice
☐High fever	☐Excess diarrhea	☐Head banging
☐Slow weight gain	☐Stiffness	☐Chronic ear infections
☐Excessive irritability	☐Congenital defect	☐Heart disease/defect
☐Hydrocephalus	☐Bleeding into brain	☐Physical abnormality

Treatments:_____
_____

Allergies/Feeding:
Does the child have any allergies to food or medication? ☐Yes ☐No
If so, what are they?_____
What kind of milk was the child started on? ☐Breast ☐Formula
How old was the child when s/he was weaned from the bottle or breast?_____Months

Developmental History

Developmental Milestones:
Did the child first sit without help between the ages of 4-8 months? ☐Yes ☐No
Did the child walk alone between 9-18 months? ☐Yes ☐No
Did the child follow simple commands between 12-18 months? ☐Yes ☐No
Did the child use simple sentences between 18-30 months? ☐Yes ☐No
Did the child first learn to ride a tricycle between 2-4 years of age? ☐Yes ☐No
Did the child first learn to ride a bicycle between 5-6 years of age? ☐Yes ☐No

Temperament:
Describe the child's early temperament. Check all that apply.

Activity level	☐Low	☐Average	☐High
Sleeping/eating schedule	☐Predictable	☐In-between	☐Unpredictable
Unfamiliar situations	☐Inhibited, cautious	☐In-between	☐Uninhibited
Concentration	☐Low	☐Average	☐High
Social	☐Very shy, timid	☐Average	☐Very friendly
Persistence with activities	☐Very persistent	☐Average	☐Gave up quickly
Sensitivity to sound	☐Sensitive	☐Average	☐Not sensitive at all
Sensitivity to touch	☐Sensitive	☐Average	☐Not sensitive at all
Sensitivity to light	☐Sensitive	☐Average	☐Not sensitive at all
Sensitivity to taste, smell	☐Sensitive	☐Average	☐Not sensitive at all
Intensity	☐Calm	☐Average	☐Emotional
Mood	☐Happy	☐Average	☐Irritable, unhappy
Separation from parents	☐No problems	☐In-between	☐Very difficult

Other:

Give the approximate age when the child toilet trained_____
Nocturnal Enuresis (past age 6): ☐Yes ☐No Until what age? ___
Did/does the child attend day care? ☐Yes ☐No To what age? ____

Educational History

Preschool/Background:
Did the child attend preschool? ☐Yes ☐No If yes, at what age?_____
Describe any problems:_____
What age did s/he enter 1st grade?_____ If later than six, why?_____
What grade is the child currently in?_____Current teacher's name:_____
School name and City _____

Academic Achievement:
Please check the item that best describes the child's CURRENT grades:
☐Superior (all A's) ☐Above average (A's and B's)☐Average (C's) ☐Below average (D's)☐ Failing ☐
Please check the item that best describes the child's grades THROUGHOUT their school experience:
☐Superior ☐Above average ☐Average ☐Below average ☐Failing
Has the child repeated any grades? ☐Yes ☐No If yes, which grade(s)?_____
Has the child skipped any grades? ☐Yes ☐No If yes, which grade(s)?_____

Academic Achievement (continued):
Has the school reported current problems with (check all that apply):

☐Reading Describe_____
☐Spelling Describe_____
☐Writing Describe_____
☐Math Describe_____
☐Social Studies Describe_____
☐Science Describe_____
☐Following Directions Describe_____
☐Other Describe_____

Testing/Special Services:
Has the child ever been evaluated for IEP/504? ☐Yes ☐No If yes, who performed the testing?_____
_____ When was the testing performed?_____
If yes, please provide a copy of the results.
Does the child receive special services at school? ☐Yes ☐No If yes, check all that apply:

☐Speech and language ☐Support for learning disability
☐Self-contained class room ☐Social work
☐Occupational Therapy ☐Physical Therapy
☐Other

Previous Diagnoses:
Has this child been diagnosed with any of the following? ☐Yes ☐No If yes, check all that apply:

☐Reading Learning Disability ☐Written Expression Learning Disability
☐Spelling Learning Disability ☐Math Language Learning Disability
☐Nonverbal Learning Disability ☐Expressive Language Disorder
☐Receptive Language Disorder ☐Autism
☐Asperger's Disorder ☐Pervasive Developmental Disorder
☐ADHD ☐Other

Medical History

Illness:
Check any of the following that the child has had:

☐Measles ☐Head Injury ☐Exposure to TB
☐Mumps ☐Poisoning (lead,lye,etc.) ☐Chicken pox
☐Loss of consciousness ☐Sleep apnea ☐German measles
☐Fainting spells ☐Whooping cough ☐High blood pressure
☐Excessive fatigue ☐Pneumonia ☐Blood transfusion

☐Ear infections ☐Asthma or hay fever ☐Anemia
☐Rheumatic fever ☐Easy bruising ☐Broken bones
☐Blood in urine ☐Worms (intestinal) ☐Skin problems
☐Urinary/kidney infections ☐Seizures ☐Binge eating
☐Self-induced vomiting or laxative abuse ☐Nausea/vomiting/diarrhea>72 hours
☐Unintentional weight loss > 5 lbs. per month

Other serious illness: Describe:_____
If yes to any, types of treatment:_____

_____

Has the child received necessary shots per medical recommendations? ☐Yes ☐No

Current medication:

Medication	Date started	Dosage/Frequency	Compliance	Notes

Has the child been hospitalized at any time? ☐Yes ☐No

Child's Age	Year	Hospital	Reason

Other:
Do you think the child has a problem with drugs or alcohol? ☐Yes ☐No
Has the child ever had individual or family therapy? ☐Yes ☐No
Name of therapist_____ When_____ Reason_____

_____
Was therapy effective?_____
Has the child had a vision of hearing test in the last year? ☐Yes ☐No
Has the child had any vision or hearing problems? ☐Yes ☐No
If yes, describe:_____
Has the child ever had a neurological exam? ☐Yes ☐No
If yes, describe:_____

Behavioral/Social History

Relationship with others:
Does the child have difficulty getting along with children his/her age? ☐Yes ☐No
Does the child have difficulty getting along with adults? ☐Yes ☐No
Does the child have a closer relationship with one parent than the other? ☐Yes ☐No
Does the child prefer playing with children: ☐His/Her own age ☐Older
☐Younger ☐One or two friends ☐Many friends

Extracurricular Activities/Interests:
What extracurricular activities is the child involved in?_____

_____

How does the child occupy him/herself in his/her free time?_____

_____

What special interests or talents does the child have?_____

_____

Discipline:
What methods do you use for discipline?
☐Spanking ☐Time-out ☐Withholding privileges ☐Withholding affection
☐Other Please describe_____
How does the child respond to discipline?_____
Who ordinarily disciplines the child?_____
Does the child ever have angry outbursts, temper tantrums, or other behaviors that have caused you concern?
☐Yes ☐No If yes, please describe:_____
Under what circumstances do these situations occur?_____

_____

How do you handle these problems?_____
Other:

Are you aware of any physical abuse experienced by this child?	☐Yes	☐No
Are you aware of any sexual abuse experienced by this child?	☐Yes	☐No
Are you aware of any verbal abuse experienced by this child?	☐Yes	☐No
Are you aware of any violence witnessed by this child?	☐Yes	☐No
Has the child ever been arrested?	☐Yes	☐No

Previously Diagnosed Family Disorders:
Please list any of the following conditions that have occurred in the child's family:

	Biological FATHER	Biological MOTHER	Father's Family	Mother's Family	SIBLINGS
Attention deficit/hyperactivity disorder					
Brain or neurological disease					
Developmental delay					
Epilepsy or seizure					
Genetic disorder					
Learning disorder					
Mental retardation					
Schizophrenia					
Bipolar Disorder					
Anxiety disorder					
Panic disorder					
Obsessive-compulsive disorder					
Depressive disorder					
Speech and language disorder					
Other					

What are your goals for treatment?

1._____
_____
_____
_____

2._____
_____
_____
_____

3._____
_____
_____
_____

Parents signature Date

Therapist signature and credentials Date