PSYCHOLOGICAL ASSOCIATES OF THE BLACK HILLS
CHILDHOOD AND FAMILY HISTORY FORM

Name: _____ Date: _____
Birth Date: _____ Sex: F M Age:_____ Grade:_____

Why concerns do you have for your child for which you are seeking assistance: _____
_____
_____

Mother's name: _____ Home Phone _____
Father's name _____ Work Phone _____
Address _____
_____

(Check if applicable): Married _____ Single ____
Separated____ Divorced_____ Age of above child at time of divorce/separation_____
Joint Custody? Yes/No Legal Custody with _____ Physical custody with _____

Please list names of **all** people living in the home.
Name, Age, Relationship to Child

_____ ____ _____
_____ ____ _____
_____ ____ _____
_____ ____ _____

Medical History and Child's Background

1. List any problems during pregnancy? (Health, Illnesses, Injuries, Medication)
_____
_____

Was pregnancy full-term? Yes / No How many weeks? _____ C-Section?_____ Forceps? ____
Breech presentation?____ Birth weight? _____lbs. _____ozs. Apgar score of _____

2. Newborn Infant Difficulties (check all that apply)

___ Born with cord around neck
___ Had trouble breathing
___Turned blue (cyanosis)
___Needed Oxygen
___Injured during birth
___Got Yellow (Jaundice)
___Born with a heart defect
___Born with other defect(s)
___Was in the hospital more than 7 days

3. Any other problems with labor or delivery?
_____

Health Conditions - Child	Never	0-1 yrs.	2-5 yrs.	6-10 yrs.	11-15 yrs.	16+
Ear infections						
Meningitis						
Seizures or epilepsy						
High fevers (over 103 F. or 39 C.)						
Head injury						
Trouble with ears or hearing						
Trouble with eyes or seeing						
Surgery						
Hospitalizations						
Heart problems						
Lead poisoning						
Allergies to food						
Allergies to environment						
Anemia						
Poisoning or overdose						
Diabetes (since when)						
Asthma (since when)						
Pneumonia						

4. Child's Physician _____ Telephone _____

Is your child currently on any medication? No Yes Please list medication(s) and reason.
_____

5. Please give any *important* medical information, injuries and reasons for hospitalizations or surgery:
_____
_____
_____

6. Please share if your child had any prolonged illnesses. If they had to take medication over along period of time, what was the medication and were there any side effects?:
_____
_____

7. Has your child ever had a neurological exam? No Yes If yes please give information.
Neurologist_____ Date _____ Reason _____

8. Do you have any other concerns about your child's health?
_____
_____

Allergies

9. Allergy to medicines? If yes, describe. _____

10. Allergies to foods. If yes, describe. _____
_____

Developmental Milestones: Please list ages at which your child first:

Sat unaided _____, Crawled _____ Walked independently _____,
Spoke single words (other than mama and dada) _____, Talked using 2-3 words _____,
Was toilet trained _____ (daytime), Toilet trained _____(at night)

11. Please list any difficulties or delays that have occurred in your child's infant years:
_____
_____

Functional Conditions (check all that apply to show when condition began or existed)	**Current**	**0-1 yrs.**	**2-5 yrs.**	**6-10 yrs.**	**11-16 yrs.**	**Never**
Sleeping Problems						
Crying often and easily						
Clingy						
Possessive with parents						
Head Banging						
Thumb sucking						
Nail biting						
Rocks back and forth						
Has tics/twitches						
Accident prone						
Temper Tantrums						
Overactivity –seems to always be moving						
Irritability						
Self-destructive behavior						
Extreme reactions to noise or sudden movement						
Tactile sensitivity (e.g. bothered by tags or other materials)						
Tendency to make odd sounds, grunts or snorts						
Tendency to twitch or jerk arms or head						
Trouble getting along with peers						
Trouble listening to authority and following rules						
Seems to zone out						
Low self image or esteem (negative self-talk)						
Eating difficulties						
Eats odd things (non-nutritive)						
Wetting or soiling problems						

Coordination	Good	Average	Poor
Walking			
Running			
Balancing			
Throwing			
Catching			
Shoelace tying			
Buttoning			

Temperament

Please indicate whether your child exhibits any of the following behaviors.

Is easily overstimulated in play No Yes _____
Seems overly energetic in play No Yes _____
Has a short attention span No Yes _____
Seems Impulsive No Yes _____
Lacks self-control No Yes _____
Overreacts to problems No Yes _____
Seems unhappy most of the time No Yes _____
Withholds affection No Yes _____
Uncomfortable meeting new people No Yes _____
Hides feelings No Yes _____
Has trouble with changes No Yes _____
Cannot calm down No Yes _____
Requires lots of attention No Yes _____
Has fears No Yes _____

11. What does your child do when he/she is stressed, angry or frustrated? _____
_____

12. How does your child express his/her sadness? _____
_____

Behavioral Symptoms – Attention / Inattention (check all that currently apply)	Not at All	Just A Little	Quite A Bit	Very Much
Fails to give close attention to details, makes careless mistakes				
Has difficulty maintaining attention in tasks or play activities				
Does not seem to listen when spoken to directly				
Does not follow through on instructions and fails to finish work				
Has difficulty organizing tasks and activities				
Avoids or reluctantly engages in tasks requiring sustained mental effort				
Often loses things necessary for tasks or activities				
Is distracted by things around him/her				
Is forgetful in daily activities				
Difficulty maintaining alertness, listening to requests, executing decisions				
Fidgets with hands or feet or squirms in seat, difficulty being still				
Leaves seat in classroom or other situations in which remaining seated is expected				
Runs about or climbs excessively in situations when it is inappropriate				
Has difficulty playing or engaging in activities quietly				
Is "on the go" or often acts as if "driven by a motor"				
Talks excessively				
Blurts out answers before questions have been completed				
Has difficulty awaiting turn				
Interrupts or intrudes on others (butts into conversations, etc)				

Behavioral Symptoms (additional)	Not at All	Just A Little	Quite A Bit	Very Much
Depressed mood or irritable mood most of the day				
Persistent fear of social or performance situations				
Decrease in pleasure in activities (things are less fun)				
Excessive fear of specific objects or situations				
Decrease or an increase in appetite				
Excessive or persistent worry about a parent or caregiver				
Difficulty sleeping or seems to sleep a lot				
Reluctance or refusal to go to school				
Fatigue or loss of energy (tires easily or seems tired often)				
Excessive need for reassurance				
Feelings of worthlessness , down on himself/herself				
Concerns about their competence or ability				
Loss of ability to concentrate				
Inability to relax				
Reluctance to be alone, wants parent or caregiver around				
Complains of aches and pains				
Feels hopeless, may wish he/she was dead				
Unusual fears or aversions				

School Concerns and Relationships

13. Did your child attend a preschool/nursery school? If yes, were there any difficulties with your child's behavior? Please share briefly:

_____

_____

14. Has your child experienced learning or academic problems? Yes / No If yes, please describe:

_____

_____

15. Was your child ever retained? If yes what grade?

_____

16. Does your child have difficulty with doing homework/daily work, taking tests, etc.?

_____

17. Has your child ever been evaluated/tested? Yes / No If so, when and where?

_____

18. Have special education services been provided in the past? Yes / No If yes, describe:

_____

19. Describe any *academic* problems reported by teachers: _____

_____

20. Describe any *behavior* problems reported by teachers:

_____

Early Educational Experience	Did Well	Some Problems	Serious Problems	Cannot Say
Learning to read in 1st, 2nd grade				
Reading level in 3rd – 6th grade				
Learning to spell in 1st, 2nd grade				
Spelling in 3rd – 6th grade				
Spelling in 4th – 6th grade				
Learning mathematics 1st – 3rd grade				
Learning mathematics 4th – 6th grade				
Writing words and sentences				
Understanding spoken directions				
Understanding written directions				
Getting homework done in school				
Paying attention in the classroom				
Getting along with other children				
Poor memory				

Communication - Speech

21. Does your child have any *speech or language* problems? Yes/No If yes, when was the problem first noticed? _____ Have there been any previous speech/language services? Yes / No If yes, when and where?

_____

22. Are there any other concerns or relevant information in relation to school that you wish to share and would assist us in meeting your child's needs**?**

_____

_____

Family History / Health

Concern	Child's Father	Child's Mother	Child's Brother(s)	Child's Sister(s)	Others: (specify)
Alcohol/Drug difficulties					
Nervousness					
Seizures or Epilepsy					
Tourettes Syndrome					
Migraine headaches					
Depression					
Anxiety or nervousness					
Emotional disturbance					
Behavior disorder					
Mood Disorder					
Reading problems					
Math problems					
Learning disability					
Speech difficulties					
Hyperactive					
Attention difficulties					

23. Are there any other family concerns or information in relation to your family that you to share and may assist us in meeting your child's needs?

_____

_____

_____

Home Behavior

24. Types of discipline you use with your child? _____
_____

25. What form of discipline do you find to be most effective? _____
_____

26. What are your child's main hobbies and interests?_____
_____

27. What does your child enjoy doing the most? _____
_____

28. What do you see as your child's strengths, abilities, talents ? _____
_____

Other Professionals

29. Has your child ever had psychological counseling or therapy? No Yes
Counselor's name _____ Reason for counseling _____
_____

30. Has your child had a psychological evaluation? Yes / No If yes, what were the results ?
(Please attach a copy if you have one). _____
_____
_____
_____