



Atlanta Psychological Services

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Check one:

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CHILD HEALTH HISTORY FORM

Today's date: _____

Child's name: _____ Age: _____ Date of birth: _____

Name of person completing this form: _____

Relationship to child: (Mother?) _____ (Father?) _____ (Other?) _____

Name of pediatrician: _____

Pediatrician's Phone number: _____ Fax: _____

Who is requesting or recommending these services for your child? (circle all that apply)

- Parent Therapist Physician**
Pediatrician Psychiatrist School
Attorney DFCS Court Other? _____

What is the reason for the visit today? _____

What are your primary concerns about your child? _____

CHECK THE FOLLOWING THAT APPLY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self-harming behavior |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Low motivation | <input type="checkbox"/> Low self-esteem |
| <input type="checkbox"/> Suicidal ideation | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Bizarre or strange behavior |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Difficulty focusing | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Anger | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Defiance | <input type="checkbox"/> Lying | <input type="checkbox"/> Hoarding food |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Sexual acting out | <input type="checkbox"/> Attention-seeking |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Language delay | <input type="checkbox"/> Learning problems |
| <input type="checkbox"/> Poor social skills | <input type="checkbox"/> Poor eye contact | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Sensory concerns | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Organization problems |
| <input type="checkbox"/> Eating disorder symptoms | <input type="checkbox"/> Low frustration tolerance | |
| <input type="checkbox"/> Motor skills or coordination problems | | |

DEVELOPMENTAL HISTORY

Length of pregnancy: _____ Child's weight at birth: _____

Any problems with pregnancy or delivery? (circle one) **YES** **NO** **DON'T KNOW**

If yes, please explain: _____

Any known alcohol or substance abuse during pregnancy? **YES** **NO** **DON'T KNOW**

If yes, please describe: _____

Any health problems at birth? **YES** **NO**

If yes, describe: _____

Was infant hospitalized for any length of time after birth? **YES** **NO**

If yes, briefly describe: _____

Any delays with developmental milestones (talking, walking, potty training, etc.)?

YES **NO** If yes, please explain: _____

Has your child ever received any of the following?

	Currently?	In the Past?	If yes, describe:
Speech Therapy			
Physical Therapy			
Occupational Therapy			

MEDICAL HISTORY

When was your child's last visit to the pediatrician? _____

Any concerns at that time? **YES NO**

If yes, please explain: _____

Does your child have hearing or vision problems? **YES NO**
If yes, are they corrected (with glasses, contact lenses, hearing aids, etc.)? _____

Has your child ever been hospitalized for general medical reasons? **YES NO DON'T KNOW**
If yes, reason and approximate date(s): _____

Has your child ever had surgery? **YES NO DON'T KNOW**
If yes, briefly describe: _____

Does your child have any chronic illness (such as diabetes, asthma, etc.)? **YES NO**
If yes, briefly describe: _____

Does your child have any medication, food, or other allergies? **YES NO DON'T KNOW**
If yes, briefly describe: _____

Does your child **currently** take any prescription medications (non-psychiatric)? **YES NO**
If yes, medication names: _____

Has your child ever had any head injuries? **YES NO DON'T KNOW**
If yes, briefly describe: _____

Has your child ever had any other major injuries? **YES NO DON'T KNOW**
If yes, briefly describe: _____

Does your child have any appetite problems or problematic weight gain or weight loss?

YES NO DON'T KNOW

If yes, briefly describe: _____

Does your child have any sleep problems or nightmares? **YES NO**

If yes, briefly describe: _____

FAMILY HISTORY

Names & ages of child's siblings: _____

Who currently lives in the home? _____

Check any family crises or problems that have occurred in child's household:

(describe further in the comments section below as needed)

Separation/divorce of parents

Parent's new job

Death of a family member

Move to a new home

Death of a pet

Birth of sibling

Serious illness of a family member

Addiction of family member

Other _____

Comments:

Does your child have opportunities to play with other children? _____

How does your child get along with other children? _____

What are your child's favorite activities? _____

EDUCATIONAL HISTORY

Name of child's school: _____

What grade is he/she in? _____ Current or most recent grades: _____

Has your child repeated any grades? (if yes, which ones?) _____

Is your child receiving special education services? **YES NO**

If yes, for what reason? (circle all that apply) **behavioral emotional educational**

Any major school discipline (suspensions, expulsions) or behavior problems in school? **YES NO**

If yes, briefly describe: _____

MENTAL HEALTH HISTORY

Has your child ever received a mental health diagnosis in the past? **YES** **NO**

If yes, what diagnosis? _____

Has your child ever seen a psychiatrist for psychiatric medication? **YES** **NO**

If yes: Name of psychiatrist ? _____ When? _____

Is your child **CURRENTLY** taking psychiatric medications? **YES** **NO**

If yes, name(s) of medication(s): _____

Has your child taken any other psychiatric medication in the past? **YES** **NO** **DON'T KNOW**

If yes, names of medications and dosages (if known): _____

Has your child ever had a psychological evaluation? **YES** **NO** **DON'T KNOW**

If yes, when and what was the diagnosis? _____

Is your child **CURRENTLY** receiving therapy or counselling for emotional or behavioral problems?

<i>(circle all that apply)</i>	Provider or Agency	Date Started	Frequency	For what issues?
Individual				
Group				
Family				
Other				

Has your child received therapy or counseling in the **PAST** for emotional or behavioral problems?

<i>(circle all that apply)</i>	Provider or Agency	Date Started	Date Stopped	Why did the therapy stop?
Individual				
Group				
Family				
Other				

Has your child ever been admitted to a psychiatric hospital? **YES** **NO**

If yes, please list date(s) and name(s) of hospitals: _____

Has your child ever had suicidal thoughts or made suicidal threats? **YES** **NO** **DON'T KNOW**

If yes, briefly describe: _____

Has your child made any suicide attempts? **YES** **NO** **DON'T KNOW**

If yes, briefly describe: _____

Has your child ever been abused or neglected? **YES** **NO** **DON'T KNOW**

If yes, circle those that apply and briefly describe:

<i>(circle all that apply)</i>	Briefly describe
Physical	
Verbal / Emotional	
Sexual	
Neglect	

Is there any history of mental health problems in the child's family?

YES **NO** **DON'T KNOW**

If yes, briefly describe: _____

How do you typically discipline your child? _____

Are there any additional concerns about your child? _____