Lindsey Kremmel, PhD

91 West Neal Street • Pleasanton, CA 94566 • Phone: 510-982-6477 • Web: www.DrLindseyKremmel.com

Child and Family History Form

Today's date: _____

Child's Name: _____ Preferred Name (if different): _____

DOB: _____ Age: _____ Gender: _____ Pronouns (she/he/they…): _____

Race/Ethnicity: _____ School Grade: _____ Name of School: _____

Form completed by: _____ Relationship to Child (Mom, Dad, etc): _____

Does the child live at more than one home (i.e. in the case of shared custody)? { } Yes { } No
If so, who has *legal* custody? _____

Child's Primary Residence

Parent/Guardian's Name: _____ Relationship to Child (Mom, Dad, etc): _____

Parent/Guardian's Name: _____ Relationship to Child (Mom, Dad, etc): _____

Address: _____ City: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email: _____

Therapist may leave a detailed message at: { } Home { } Work { } Cell { } Email

Who else lives at this residence?: _____

Child's Secondary Residence (if applicable)

Parent/Guardian's Name: _____ Relationship to Child (Mom, Dad, etc): _____

Parent/Guardian's Name: _____ Relationship to Child (Mom, Dad, etc): _____

Address: _____ City: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email: _____

Therapist may leave a detailed message at: { } Home { } Work { } Cell { } Email

Who else lives at this residence?: _____

Child/Teen's Telephone: _____ Therapist may leave detailed message? { } Yes { } No

Emergency contact person: _____ Relationship to child: _____ Phone #: _____

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Referred by (How did you hear about my practice?): _____

Main problem/major reason for seeking help at this time and how long this has been a problem:

_____

_____

_____

Describe any other problems your child is currently having:

_____

Describe the impact of your child's problems (on family, friends, school, etc):

_____

Medical & Psychiatric History

Briefly describe *past* and *current* psychological treatment including psychotherapy, medication, testing, etc.:

Dates of Treatment	Facility/Therapist/Doctor	Reason for Treatment	Helpful? (Yes/ No)

Is your child currently taking any medications? { } Yes { } No If yes, include the following information:

Name of Medication	Dosage	Prescribed by	Date Started

Indicate if your child has had any of the following:

Condition	Yes	Age	Details
Serious Illness/Injury/Medical condition			
Head injuries			
Hospitalizations for psychiatric reasons			
Hospitalizations for medical reasons/Surgeries			
Allergies (medication, food)			
Asthma			

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Does this child have a history of abuse (physical, sexual, emotional, neglect)? { } Yes { } No
Is there any legal action that may have affected your child? { } Yes { } No

Developmental History

During Pregnancy: { } alcohol/drugs { } illness { } accident { } other problems { } problems during delivery
Was/is child breastfed? { } Yes { } No If yes, for how long? _____
As a baby, was/is child: { } colicky { }head banging { } hard to regulate (sleeping/eating)
{ } hard to soothe { } more interested in things than people

Relationship Development Check each item that describes your child:

	Now	Past		Now	Past
Prefers to be alone			Is demanding and bossy		
Is alone a lot, but dislikes this			Poor relationship with siblings		
Is shy			Bullies/teases others		
Has few friends			Fights with others		
Poor relationships with peers			Plays with younger/older kids		
Plays with “problem kids”			Conflict with parents		
Is picked on/bullied			Poor relationships with teachers		

School Environment Check all that apply:

	Now	Past		Now	Past
Resource classes/special ed.			Continuation school		
Gifted program			Home school		
Speech therapy			Independent study		

School Check any area of concern:

	Now	Past		Now	Past
Dislikes school			Missed many school days		
Works hard but does poorly			Repeated a grade		
Unmotivated			Discipline referrals, detentions		
Learning problems			Suspensions/Expulsions		

Discipline: Forms of discipline used in the home: _____

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Family Stresses Describe any/all that apply:

	Please describe
Marital problems	
Marital separation/Divorce	
Custody disputes	
Financial problems/Job Loss	
Housing problems	
Death of friend/relative/pet	
Other stress: _____	

Indicate if any **family members or relatives** have the following:

Problem:	**Family Member (mom, dd, sister, uncle, etc):**
Depression	
Bipolar Disorder (Manic-Depressive)	
Nervous disorders/Anxiety	
Learning disabilities/delays	
Problems with attention/hyperactivity/impulse control (ADHD)	
Autism Spectrum Disorders	
Problems with aggressive behavior as adult or child	
Other mental health problems: _____	

What are your family supports? (clubs, church, friends, clubs etc.)? _____

What are your family strengths? _____

Describe your child's strengths. What do you love about your child? _____

_____

Additional information you want me to know: _____

_____