

Medical / Developmental History

Birth weight _____ Problems with birth / delivery? _____

Age walked _____ Talked well _____ Toilet Trained _____

Childhood diseases / Health problems? _____

Allergies? _____

Current weight _____ height _____ Recent weight loss? _____

Medications:

Name _____ dose/day _____ physician _____
Name _____ dose/day _____ physician _____

Cigarettes? ___ No ___ Yes _____ packs per day Average hours of sleep per night? _____

Alcohol? ___ No ___ Yes age of first use _____ typical use pattern _____

Drugs? ___ No ___ Yes age of first use _____ typical use pattern _____

Prior counseling / therapy / substance abuse treatment?

Prior counseling / therapy / substance abuse treatment for family members?

Educational and Social History:

School _____ Grade _____ Teacher _____
Most recent grades _____ Special Education? _____ Behavior Problems? _____

Childhood abuse or history of trauma?

Interests and hobbies?

Friendship / social problems?

Describe the problem or issue that brings this child to evaluation or treatment:

Signed _____ Relationship to Child _____ Date _____