THE GUIDANCE CENTER, ADULT AND FAMILY SERVICES, INC.

I.D.#_____

CHILDREN'S HISTORY FORM

Parent/Guardian to complete for young children.

Child's Name: _____ Date of Birth_____

Name of adult completing form: _____ Relation: _____

FAMILY AND DEVELOPMENTAL HISTORY
CURRENT HOUSEHOLD

	MOTHER	FATHER	STEP-PARENT	OTHER ADULTS
NAME				
DATE OF BIRTH				
DATE OF MARRIAGE(S)				
DATE OF DIVORCE(S)				
RACE				
CURRENT EMPLOYER				
HOW LONG				
INCOME				
OCCUPATION (HIGHEST GRADE COMPLETED)				

Names and ages of brothers and sisters living at home: _____

_____

Names and ages of brothers and sisters living elsewhere: _____

_____

With whom are they living? _____

Who supports this child? _____

LIVING ARRANGEMENT
How many residences has child lived in since birth? _____

Towns or cities these residences have been located in? _____

Does child share a room with anyone else? No Yes Shares with: _____

Sleeps in the same bed with roommate? No Yes

DEVELOPMENTAL HISTORY

BIRTH

Was this child Planned Unplanned Adopted If adopted, what age adopted:_____

Length of pregnancy: _____months Length of labor _____hours

Was pregnancy easy? No Yes Premature? No Yes If premature, how early:_____

Type of delivery: Spontaneous Induced Forceps Caesarean

Was the infant Head first Feet first Breech

Did mother receive any medication during delivery? No Yes What kind: _____

Was it necessary to give infant oxygen? No Yes How long:_____

Did infant require blood transfusion? No Yes X-ray? No Yes EEG No Yes

Did infant receive any medication? No Yes If yes, what kind? _____

INFANCY

During the first two weeks, did the infant show any of the following conditions (check all that apply):

Appear yellow Blue lips Difficulty breathing Convulsions/twitching
Vomiting Irritable Slow in responding Deformed Very high fever

As a baby, was your child breast-fed? No Yes If yes, how long? _____

As a baby, did your child fee well? No Yes If no, what was the problem? _____

_____

Any problems with Diarrhea Constipation Colic Please specify:_____

_____

For how long? _____

Any problems with Sleep Head banging Thumb sucking Teeth grinding Temper tantrums

If yes, please describe: _____

_____

When did your child stand alone? _____ Walk? _____ Use words _____

Speak in sentences? _____ If there were any problems, please describe: _____

_____

When was your child toilet trained: Bladder—day _____ night _____

Bowles_____

Any problems with toilet training? No Yes If yes, please describe _____

_____

SCHOOL AGE
Did your child attend a preschool/day care program? No Yes If yes, what age(s)_____

What is your child's current grade level? 1 2 3 4 5 6 7 8 9 10 11 12

Recent grades: A B C D E

Has there been a change in grades in the past 6 months? No Yes If yes, was change Down Up

Has your child ever been in a special education program? No Yes What grade(s): _____

What type of special education program? Learning Disabled Emotionally Impaired Resource Room

Has your child ever received any special educational help No Yes If yes, when_____

What subjects_____

Has your child ever been suspended from school? No Yes What grade(s) _____

Please describe suspension(s)_____

Has your child ever been expelled from school? No Yes What grade(s) _____

Please describe expulsion(s)_____

ADOLESCENCE
If your child is a teenager, what physical changes have you noticed? _____

_____

Have you noticed a change in your child's attitude towards:
School Family Friends Recreational Activities If yes, please describe: _____

_____

Does your teenager have a paying job? No Yes If yes, where? _____

How many hours per week? _____ What future plans does your teenager have? _____

_____

DRINKING HISTORY
Age at time of: First drink_____ First intoxication_____ Recognition of problem_____

Drink preference(s): _____

Quantity: _____ Frequency: _____

DRUG HISTORY (List all drugs used)

Type of drug used				
Age at time of first use				
Quantity				
Frequency				

Chemical Dependency Treatments

Inpatient/Outpatient/Residential	Facility	Dates

Family Use of Alcohol, other drugs (include mother, father, step-parents, siblings)

Relationship	Type	Quantity	Frequency

Has any parental figure ever undergone treatment or received help for an alcohol or drug problem?

No Yes If yes, who_____

When? _____ Where_____

PREVIOUS PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Has this child ever been seen for emotional problems? No Yes If yes, when _____

Whom_____ Where _____

Have other family members had emotional problems? No Yes If yes, who_____

Please describe: _____

Has this child ever lived away from home because of emotional problems or family problems? No Yes

If yes, please explain _____

Any history of Neglect Emotional Abuse Physical Abuse Sexual Abuse Sexual perpetration

If yes, please describe: _____

Protective Services involvement? No Yes If yes, please describe: _____

Has this child ever been in trouble with the court and/or police? No Yes If yes, please describe: _____

_____