The Jones Center for Children's Therapy and Assessment
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CHILD (AGES 2 – 11) PATIENT HISTORY

Name: _____ **Ethnicity:** _____ **DOB:** _____ **Age:** _____

Dear Parent,
To help establish your child with our practice, please provide us with his/her complete medical and mental health histories. Thank you and we look forward to working with you and your child!

In your own words, please describe why you are seeking services for your child: _____

Were you referred by an outside source, such as a pediatrician? Who? _____

Family Members/Others Residing in Home	**Age**	**Relationship to Child**

How does this child get along with other family members in the home? Defiant? Antagonistic? Alliances? Other problems?

Family Members/Others Residing Outside Home	**Age**	**Relationship to Child**

How does this child get along with family members/important people residing outside the home? _____

Frequency of visitation/contact with parent/guardian(s) in second household (if applicable): _____

Parents'/Legal Guardians' Marital Status: Married Divorced Separated Never Married Other:_____
If separated or divorced, how old was your child at that time? _____ How did he/she adapt? _____

Maternal Family Psychiatric History (If so, who?)
Depression/sadness_____
Suicidal ideation/attempt_____
Anxiety/excessive worry_____
Panic attacks_____
Posttraumatic Stress Disorder _____
Bipolar Disorder_____

Paternal Family Psychiatric History (If so, who?)
Depression/sadness_____
Suicidal ideation/attempt_____
Anxiety/excessive worry_____
Panic attacks_____
Posttraumatic Stress Disorder _____
Bipolar Disorder_____

Obsessive-compulsive tendencies_____
Schizophrenia_____
Attention problems/ADHD_____
Learning problems _____
Autism Spectrum Disorder _____
Alcohol/drug abuse_____
Problems with the law_____
Seizures_____
Other_____

Obsessive-compulsive tendencies_____
Schizophrenia_____
Attention problems/ADHD_____
Learning problems _____
Autism Spectrum Disorder _____
Alcohol/drug abuse_____
Problems with the law_____
Seizures_____
Other_____

Does this child have a sibling(s) or half-sibling(s) who suffers any of the aforementioned psychological issues/disorders? Y or N If yes, who and what? _____

_____

Birth History

Was the pregnancy planned? Y or N Desired? Y or N Prenatal care received? Y or N Is he/she adopted? Y or N
Complications during pregnancy? Y or N If Yes, please explain:_____

_____

Nausea:_____ Vomiting:_____ Swelling:_____ Headaches/migraines:_____ Diabetes:_____
Other illnesses:_____ Bed rest:_____Why?_____How long?_____
Tobacco use: _____ How much:_____ Alcohol use:_____ How much:_____
Prescription drug use: _____What:_____ Illicit drug use:_____What:_____
Length of pregnancy:_____ Was labor induced? Y or N If Yes, why? _____

_____

How was he/she delivered? (i.e., vaginally, with forceps, with vacuum assistance, etc.)_____

_____

Weight at birth: _____ Complications during delivery? Y or N If Yes, please explain:_____

_____

Did this child require admission into the neonatal intensive care unit (NICU)? Y or N If Yes, how long and why? _____

_____

This child has met majority of his/her developmental milestones in a timely manner: _____Yes _____No
Age he/she began: Crawling _____ Walking _____ Talking - single words _____ 2+ word sentences _____
This child's overall development is occurring: _____Slowly _____Normally _____Quickly

Medical History

Heart problems Y or N If Yes, please explain:_____
Lung problems Y or N If Yes, please explain:_____
Eye problems Y or N If Yes, please explain:_____
Ear infections/tubes Y or N If Yes, please explain:_____
Speech problems Y or N If Yes, please explain:_____
Sensory problems Y or N If Yes, please explain:_____
Broken bone(s) Y or N If Yes, please explain:_____
Surgery Y or N If Yes, please explain:_____
Allergies Y or N If Yes, please explain:_____
Asthma Y or N If Yes, please explain:_____
Seizures Y or N If Yes, please explain:_____
Head injury/concussion/unconsciousness Y or N If Yes, please explain:_____

_____

Other:_____
Are his/her immunizations current? Y or N If No, please explain:_____
If your child has been/is on psychoactive medication, how old was he/she when it was first prescribed?_____
By whom? _____ For what? _____

_____

Current regularly used medications, including prescriptions, over-the-counters, herbals, and/or essential oils:

Medication	Dosage	Times/Day	For what reason

Additional prescription medications used in the past:

Medication	For what reason	Reason for discontinuation

Academic History

Current grade (or most recently completed)?_____ School and ISD?_____
Has this child ever repeated a grade? Y or N If Yes, what grade(s)?_____ Who initiated retention? _____
Why?_____
Has he/she ever received RtI, 504, Special Education (IEP), or other intervention services? Y or N If Yes, how was he/she qualified and what service(s) did he/she receive?_____

Is this child currently experiencing academic problems? Y or N If Yes, please explain:_____

Please describe what kind of grades/marks he/she generally achieves in school:_____

Has this child ever received formal testing through the school, apart from standardized testing? Y or N If Yes, please explain:_____

Does this child exhibit behavioral problems at school? Y or N If Yes, please explain:_____

Has he/she ever received detention, in school suspension, out of school suspension, or expulsion? Y or N If Yes, please explain:_____
At what level do you estimate your child's intelligence? _____below average _____average _____above average

Mental and Emotional History

Please indicate if Yes, No, or Sometimes (ST) your child experiences the following symptoms:

SYMPTOM	Y	N	ST	NOTES
Attention problems				
Hyperactivity				
Impulsivity				
Academic problems				
Failing classes				
Communication problems				
Language/speech problems				
Memory problems				
Anger				
Rages				
Anxiety				
Panic attacks				
Depression/sadness				
Negative self-talk				
Low self-esteem				
Irritability				

Low frustration tolerance				
Threatens to harm self				
Acts of self-harm (i.e., cutting)				
Suicidal thoughts				
Manipulative tendencies				
Externalizes blame				
Elevated moods/mania				
Mood swings				
Obsessive-compulsive tendencies				
Repetitive behavior				
Restricted pattern/range of interests				
Trouble with change and/or transitions				
Aggressive - verbal and/or physical				
Threatens to harm others				
Defiance/intentional breaking of rules				
Temper tantrums				
Emotional outbursts/meltdowns				
Lying/deceitfulness				
Stealing				
Disrespect toward adults				
Daytime toileting accidents				
Bedwetting				
Sleep difficulties				
Nightmares/terrors				
Poor personal hygiene				
Hears things that are not there				
Sees things that are not there				
Difficulty making/keeping friends				
Poor social skills				
Lacks empathy				
Other difficulties				

Please provide elaboration on any specific symptom(s) which warrants direct intervention: _____

Has this child been abused? Y or N (circle one and all that may apply)
Sexually Verbally Physically Mentally Emotionally Other: _____
When? _____ Who was the abuser? _____
Has this child experienced any other traumatic event(s)? Y or N If Yes, please explain: _____

Have there been any significant deaths or losses in the family? Y or N If Yes, please explain: _____

Has this child ever participated in therapy? Y or N Play Individual Family Group Undergone formal testing? Y or N
With whom? _____ When? _____ How long? _____
Was a diagnosis assigned? Y or N. If yes, what? _____
Was the previous treatment beneficial? Y or N or Somewhat Please explain: _____

Has your child ever been admitted for inpatient psychiatric care? Y or N If Yes, please provide details regarding admission dates, precipitating events, treatment received, perceived benefit, etc. _____

Parenting

Do you believe you do an effective job parenting this child? Y or N Please explain:_____

_____

What discipline technique do you use that is most effective?_____

Least effective:_____

Do adults/caregivers in this child's life agree on how to discipline him/her? Y or N Is this a problem for you, this child, and/or your family? Y or N Please explain:_____

_____

Strengths and Weaknesses

What do you think are this child's biggest personal strengths?

1. _____

   _____

2. _____

   _____

3. _____

   _____

What do you think are this child's biggest personal weaknesses/limitations?

1. _____

   _____

2. _____

   _____

3. _____

   _____

Please provide any additional information you think we need to know.

_____

_____

_____

_____

_____

_____

_____

Signature and Date