Dr. Laura Nusbaum
Clinical Psychologist
PSY 24639

CONFIDENTIAL CHILD HISTORY AND INFORMATION

Please complete this form and bring it with you to your first session.

Biographical Information

Child's name: _____

Gender:_____

Address: _____

Date of birth: _____ Age: _____

Grade:_____ School:_____

Ethnicity/race: _____

Your name: _____

Relationship to the child: _____

Are you the child's legal guardian? _____

What are your current concerns?: _____

_____

_____

_____

How long have you had these concerns?:_____

_____

_____

Factors that might be contributing to or affecting the problem: _____

_____

_____

Referred by: _____

Emergency contact name: _____

Emergency contact phone: _____

Emergency contact's relationship to the child: _____

Your home phone: _____ Is it OK to leave a message? Yes No

Your cell phone: _____ Is it OK to leave a message? Yes No

Your work phone: _____ Is it OK to leave a message? Yes No

Your Email: _____ Is it OK to email you? Yes No

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Developmental History

Please describe any complications with pregnancy, labor or delivery: _____

_____

_____

Describe child as an infant/baby:	Yes	No
Ate well		
Slept well		
Was colicky or fussy		
Was easy to soothe		
Was very sensitive to external stimuli		
Appeared attached to caregivers		
Experienced major disruption or trauma		

At what age did your child:	Age
Sleep through the night	
Crawl	
Walk by him/herself	
Use 2-3 words together	
Potty train	
Read	
Begin puberty	

Please describe your child's sleeping habits: _____

_____

_____

How well does your child soothe him/herself? What activities or behaviors help soothe your child when s/he is upset? _____

_____

_____

_____

How would you describe your child's personality and temperament? _____

_____

_____

_____

What are your child's strengths? _____

_____

_____

_____

Health History

How would you describe the child's physical health? Excellent Good Fair Poor

Does the child have any significant medical problems (now or in past)?_____

_____

_____

Does the child take any medications, including psychiatric medications (now or in past)? _____

Name and location of child's Pediatrician: _____

_____

Mental Health History

Please indicate the frequency of the following behaviors:

	Never	Sometimes	Often
Cries excessively at home, school or other places			
Acts lethargic, withdrawn or uninterested in favorite activities			
Has angry/emotional outbursts that are hard to manage			
Expresses a wish to harm him/herself or die			
Self-injures (cuts, burns, etc.)			
Worries excessively			
Has unusual fears			
Is inflexible or excessive with specific behaviors (hand-washing, re-checking, routines, etc.)			
Gets along well with peers (plays, makes friends easily)			
Has problems/conflicts with peers			
Identifies and talks about a variety of feelings			
Gets in trouble at school or home			
Is fidgety, on-the-go/moving, squirmy			
Fails to complete tasks (homework, chores)			
Interrupts others or blurts out			
Is distracted or daydreaming			
Other concerning behaviors – describe below			

Has the child ever seen anyone for psychotherapy? No Yes

If YES, please describe nature and duration of treatment: _____

_____

_____

_____

If YES, did s/he receive a psychological diagnosis? Please include: _____

_____

Has the child ever been hospitalized for psychiatric reasons? No Yes

Has the child ever tried to harm or kill him/herself? No Yes

Is the child currently under the care of a psychiatrist/psychologist? No Yes

If YES (Name/Location): _____

_____

Has the child ever been in a physical fight that resulted in injury (for you or someone else)? If YES, please describe the event(s): _____

_____

_____

Has the child ever had problems with substance use (alcohol, prescription medications, or illicit substances)? If YES, please describe: _____

_____

_____

Family History

Please list all the people currently living in the same household with the child (including yourself and the child):

Name	Age	Relationship to child

Please indicate if members of the child's family have experienced any of the following:

	Mother	Father	Siblings	Mother's family	Father's family
ADD/ADHD					
Autism Spectrum or Asperger's Disorders					
Substance Abuse					
Physical/ Sexual Abuse or Trauma					
Depression					
Anxiety Disorders					
Psychosis or Schizophrenia					
Bipolar Disorder					
Suicide					
Other:					

Please briefly describe any difficult family events (e.g. loss, divorce, moving):

_____

_____

_____

_____

How did your child react to these events? _____

_____

_____

Please list and describe your child's closest relationships (may be outside the family):

_____

_____

_____

_____

What are your family's strengths? _____

_____

_____

_____