Child Social and Developmental History

Child's Name: ____ Date of Birth: ___________________

Today's Date: _______________________

Were you referred? ❒ Yes ❒ No If yes, by whom? ____

Reason(s) for seeking counseling: ____

____

____

____

Theories regarding concerns: ____

____

____

Previous strategies to address concerns: ____

____

Mental Health History

Has your child seen a psychiatrist or therapist in the past? ❒ Yes ❒ No If yes, please list below:

Provider Name	Age	Seen from MM/YY - MM/YY	Outcome

Has your child exhibited any of the following: Circle Y (Yes) or N (No)?

- Feelings of sadness for two or more weeks — Y N
- Social isolation or withdrawal — Y N
- Self-harm or talk of hurting oneself — Y N
- Racing heartbeat, headaches or belly aches — Y N
- Fighting or having a desire to harm others — Y N
- Severe, out-of-control behavior that can hurt oneself or others — Y N
- Intense worries or fears that get in the way of daily activities — Y N
- Extreme difficulty concentrating — Y N
- Severe mood swings — Y N
- Making excuses to miss school — Y N
- Extreme excitability for long periods of time — Y N
- Constantly defying authority — Y N

Has your child ever been diagnosed with a mental health condition? ________________________________

____

Household Composition

Name	Age	Relationship to Child

Strengths

What do you like about your child? ____

____

Child's interests and hobbies: ____

____

Child's talents and skills: ____

____

School and Academic Functioning

School: ____ Phone: ____________________

Teacher: ____ Grade: ______________

Current grades: ________ Best: ________ Worst: __________

Any behavior or social concerns: ____

____

Friendships (Include number, quality, favorites, and quality of interactive play): ________________________

____

____

Medical History

Pediatrician: ________________________________ Practice: ______________________________

Phone:_________________

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Medications (Name and dosing): ____

____

Medical Conditions, Injuries, Hospitalizations? ______________________________

____

Allergies: ____

Sleeping habits: ______________________ Eating Habits: _________________________

Developmental/Birth History

Is your child adopted? Yes No

If so, at what age and from where? ____

Tell me about your child's birth: ____

____

Complications at birth: ____

____

What was your child like as a baby (Temperament)? ____________________________

____

Talking? __________________________ Walking? _____________________________

Toilet Training? ____

Bedwetting or toileting accidents: ____

Attachment History Disruptions

Discipline (Method used, effectiveness, who provides): __________________________

____

Primary goal of misbehavior: ____

____

Trauma Exposure (Abuse, death, loss, etc.): ______________________________________

____

____

Trauma assessment completed? ❒ Yes ❒ No

Emotional Life: (When do they express the emotion, how do they express the emotion)

Sad: ______________________ ______________________

Mad: ______________________ ______________________

Fear: ______________________ ______________________

Does your child internalize or externalize their emotional state? ______________________

Parent's relationship: (Years Married, Conflict, Etc.)

____

____

Family Relationships: (Length and quality of relationships)

Mother/Step Mother: ______________________

____

Father/Step Father: ______________________

____

Siblings: ______________________

____

Grandparents: ______________________

____

Other significant family member(s):______________________

Pets: ______________________

Spiritual Beliefs: ______________________

____

Current Family Stressors: ______________________

____

Parent's Psychiatric and Trauma History (Diagnosis, traumatic events, etc.)

Mother: ______________________

____

Father: ______________________

____

Treatment Goals

1. ______________________
2. ______________________
3. ______________________
4. ______________________

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