

# Christian Family Care Agency

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## History Form - Child

(To Be Completed By Parents)

Child's name: \_\_\_\_\_ Today's date \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

Home address: \_\_\_\_\_  
Street city state zip

Home telephone number: \_\_\_\_\_ School \_\_\_\_\_  
Area code Number

Present placement of child (place check in appropriate bracket):

	<u>Column A</u> Adults with whom <u>Child is living</u>	<u>Column B</u> Non-residential adults <u>involved with child</u>
Natural mother	( )__	( )__
Natural father	( )__	( )__
Stepmother	( )__	( )__
Stepfather	( )__	( )__
Adoptive mother	( )__	( )__
Adoptive father	( )__	( )__
Foster mother	( )__	( )__
Foster father	( )__	( )__
Other (specify)	( )__	( )__

Place the number 1 or 2 next to each checked in Column A and provide the following information about each person:

1. Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business name: \_\_\_\_\_ Business phone: \_\_\_\_\_

Business address: \_\_\_\_\_  
Street City State Zip

2. Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business name: \_\_\_\_\_ Business phone: \_\_\_\_\_

Business address: \_\_\_\_\_  
Street City State Zip

Place the number 3 next to the person checked in Column B on the previous page who is most involved with the child and provide the following information:

3. Name \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business address: \_\_\_\_\_  
Street City State Zip

Source of referral:

Name \_\_\_\_\_

Business Address \_\_\_\_\_

Purpose of consultation (brief summary of the main problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREGNANCY**

Complications:

Excessive vomiting \_\_\_\_\_ hospitalization required \_\_\_\_\_

Excessive staining or blood loss \_\_\_\_\_

Threatened miscarriage \_\_\_\_\_

Infection(s) (specify) \_\_\_\_\_

Toxemia \_\_\_\_\_

Operation(s) (specify) \_\_\_\_\_

Other illness (es) (specify) \_\_\_\_\_

Smoking during pregnancy \_\_\_\_\_ average number of cigarettes per day \_\_\_\_\_

Alcoholic consumption during pregnancy \_\_\_\_\_

Describe if beyond an occasional drink \_\_\_\_\_

Medications taken during pregnancy \_\_\_\_\_

X-ray studies during pregnancy \_\_\_\_\_

Duration \_\_\_\_\_ (weeks)

**DELIVERY**

Type of labor: spontaneous\_\_\_\_\_ induced

Forceps: high\_\_\_\_\_ mild\_\_\_\_\_ low

Duration of labor\_\_\_\_\_ hours

Type of delivery: vertex (normal)\_\_\_\_\_ breech\_\_\_\_\_ Caesarean

Complications: cord around neck

cord presented first

Hemorrhage

Infant injured during delivery

Other (specify)\_\_\_\_\_

Birth weight

Appropriate for gestational age (AGA)

Small for gestational age (SGA)

**POST-DELIVERY PERIOD** (while in the hospital)

Respiration: immediate \_\_\_\_\_ delayed (if so, how long) \_\_\_\_\_

Cry: immediate \_\_\_\_\_ delayed (if so, how long) \_\_\_\_\_

Mucus accumulation \_\_\_\_\_

Apgar score (if known) \_\_\_\_\_

Jaundice \_\_\_\_\_

Rh Factor \_\_\_\_\_ transfusion \_\_\_\_\_

Cyanosis (turned blue) \_\_\_\_\_

Incubator care \_\_\_\_\_ Number of days \_\_\_\_\_

Suck: strong \_\_\_\_\_ weak \_\_\_\_\_

Infection (specify) \_\_\_\_\_

Vomiting \_\_\_\_\_ diarrhea \_\_\_\_\_

Birth defects (specify) \_\_\_\_\_

\_\_\_\_\_

Total number of days baby was in the hospital after the delivery \_\_\_\_\_

**INFANCY-TODDLER PERIOD**

Were any of the following present, to a significant degree, during the first few years of life? If so, describe.

- Did not enjoy cuddling \_\_\_\_\_
- Was not calmed by being held and/or stroked \_\_\_\_\_
- Colic \_\_\_\_\_
- Excessive restlessness \_\_\_\_\_
- Diminished sleep because of restlessness and easy arousal \_\_\_\_\_
- Frequent head banging \_\_\_\_\_
- Constantly into everything \_\_\_\_\_
- Excessive number of accidents compared to other children \_\_\_\_\_

**DEVELOPMENTAL MILESTONES**

If you can recall, record the age at which your child reached the following developmental milestones.

If you cannot recall, check item at right.

	I cannot recall exactly, but to the best of my recollection it occurred
<u>age</u>	<u>early</u> <u>at the normal time</u> <u>late</u>
Smiled _____	
Sat without support _____	
Crawled _____	
Stood without support _____	
Walked without support _____	
Spoke first words besides "ma-ma" and "da-da" _____	
Said phrases _____	
Said sentences _____	
Bowel trained, day _____	
Bowel trained, night _____	
Bladder trained, day _____	
Bladder trained, night _____	
Rode tricycle _____	
Rode bicycle (without training wheels) _____	
Buttoned clothing _____	
Tied shoelaces _____	
Named colors _____	
Named coins _____	
Said alphabet in order _____	
Began to read _____	

**COORDINATION**

Rate your child on the following skills:

	<u>Good</u>	<u>Average</u>	<u>Poor</u>
Walking _____			
Running _____			
Throwing _____			
Catching _____			
Shoelace tying _____			
Buttoning _____			
Writing _____			
Athletic abilities _____			

**COMPREHENSION AND UNDERSTANDING**

Do you consider your child to understand directions and situations as well as other children his or her age? \_\_\_\_\_ If not, why not? \_\_\_\_\_

How would you rate your child's overall level of intelligence compared to other children?  
 Below average \_\_\_\_\_ Average \_\_\_\_\_ Above average \_\_\_\_\_

**SCHOOL**

Rate your child's school experiences related to academic learning:

	Name of school & phone number	Good	Average	Poor
<b>Day care</b>				
<b>Nursery school</b>				
<b>Kindergarten</b>				
<b>Current grade</b>				

How many hours a day does your child attend school and/or daycare/preschool? \_\_\_\_\_

To the best of your knowledge, at what grade level is your child functioning:

reading \_\_\_\_\_ spelling \_\_\_\_\_ arithmetic \_\_\_\_\_

Has your child ever had to repeat a grade? If so, when \_\_\_\_\_

Present class placement: regular class \_\_\_\_\_ special class (if so, specify) \_\_\_\_\_

Kinds of special therapy or remedial work your child is currently receiving \_\_\_\_\_

Describe briefly any academic school problems \_\_\_\_\_

Rate your child's school experience related to behavior:

	Name of school	Good	Average	Poor
Day care				
Nursery school				
Kindergarten				
Current grade				

Does your child's teacher describe any of the following as significant classroom problems?

Doesn't sit still in his or her seat \_\_\_\_\_

Shouts out; doesn't wait to be called upon \_\_\_\_\_

Won't wait his or her turn \_\_\_\_\_

Does not cooperate well in group activities \_\_\_\_\_

Typically does better in a one-to-one relationship \_\_\_\_\_

Doesn't respect the rights of others \_\_\_\_\_

Doesn't pay attention during storytelling \_\_\_\_\_

Describe briefly any other classroom behavioral problems \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### PEER RELATIONSHIPS

Does your child seek friendships with peers? \_\_\_\_\_

Is your child sought by peers for friendship? \_\_\_\_\_

Does your child play primarily with children his or her own age? \_\_\_\_\_ younger \_\_\_\_\_ older

Describe briefly any problems your child may have with peers \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? \_\_\_\_\_

\_\_\_\_\_  
What are child's areas of greatest accomplishment? \_\_\_\_\_

\_\_\_\_\_  
What does your child enjoy doing most? \_\_\_\_\_

\_\_\_\_\_  
What does your child dislike doing most? \_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

Childhood diseases (describe any complications) \_\_\_\_\_

Operations \_\_\_\_\_

Hospitalizations for illness (es) other than operations \_\_\_\_\_

Head injuries \_\_\_\_\_

With consciousness \_\_\_\_\_

Without consciousness \_\_\_\_\_

Convulsions \_\_\_\_\_

With fever \_\_\_\_\_ Without fever \_\_\_\_\_

Coma \_\_\_\_\_

Meningitis or encephalitis \_\_\_\_\_

Immunization reactions \_\_\_\_\_

Persistent high fevers \_\_\_\_\_ highest temperature ever recorded \_\_\_\_\_

Eye problems \_\_\_\_\_

Ear problems \_\_\_\_\_

Poisoning \_\_\_\_\_

**PRESENT MEDICAL STATUS**

Present height \_\_\_\_\_ present weight \_\_\_\_\_

Present illness (es) for which child is being treated \_\_\_\_\_

Medications child is taking on an ongoing basis \_\_\_\_\_

**FAMILY HISTORY - MOTHER**

Current Age \_\_\_\_\_ Age at time of pregnancy with patient \_\_\_\_\_

Number of previous pregnancies \_\_\_\_\_ Number of spontaneous abortions (miscarriages) \_\_\_\_\_

Number of induced abortions \_\_\_\_\_

Fertility problems (specify) \_\_\_\_\_

School:

Highest grade completed \_\_\_\_\_

Learning problems (specify) \_\_\_\_\_

Behavior problems \_\_\_\_\_

Medical problems (specify) \_\_\_\_\_

Have any of your blood relatives (not including siblings) ever had problems similar to those your child has?  No,  Yes. If yes, please describe \_\_\_\_\_

**FAMILY HISTORY – FATHER**

Current Age \_\_\_\_\_ Age at the time of the patient’s conception \_\_\_\_\_

Fertility problems (specify) \_\_\_\_\_

School:

Highest grade completed \_\_\_\_\_

Learning problems (specify) \_\_\_\_\_

Behavior problems \_\_\_\_\_

Medical problems (specify) \_\_\_\_\_

Have any of your blood relatives (not including siblings) ever had problems similar to those your child has?  No,  Yes. If yes, please describe \_\_\_\_\_



## ASSESSMENT INDICATOR FOR CHILDREN/ADOLESCENTS

Parents: It will be helpful to the counseling process to know if your child exhibits any of the following behaviors, or feelings that apply. When marking the form, consider all parts of your child's life (at school, at home, etc.)

For the behaviors listed below, in the space provided at the left, please **check (3)** any behaviors, which apply, **stating when problem(s) identified began:**

- \_\_\_\_\_ Child avoids tasks requiring sustained mental effort.
- \_\_\_\_\_ Child experiences difficulty organizing tasks or activities.
- \_\_\_\_\_ Child is forgetful in normal daily activities.
- \_\_\_\_\_ Child is easily distracted by external stimuli.
- \_\_\_\_\_ Child has difficulty following directions.
- \_\_\_\_\_ Child has difficulty paying attention to tasks (may shift from one uncompleted task to another.)
- \_\_\_\_\_ Child loses things needed for tasks or activities.
- \_\_\_\_\_ Child makes careless mistakes or fails to pay attention to details.
- \_\_\_\_\_ Child often fails to listen.
- \_\_\_\_\_ Child's actions often are physically dangerous.
- \_\_\_\_\_ Child often talks excessively.
- \_\_\_\_\_ Child has problems playing quietly.
- \_\_\_\_\_ Child has problems remaining seated when required to do so.
- \_\_\_\_\_ Child fidgets with hands or feet, squirms in seat.
- \_\_\_\_\_ Child always on the go as if "driven by motor."
- \_\_\_\_\_ Child blurts out answers to question before question is completed.
- \_\_\_\_\_ Child frequently interrupts others.
- \_\_\_\_\_ Child has problems waiting turn at play or other activities.

For the behaviors listed below, in the space provided at the left, please **check (3)** any behaviors, which apply, **stating when problem(s) identified began:**

- \_\_\_\_\_ Child often loses temper.
- \_\_\_\_\_ Child frequently argues with adults.
- \_\_\_\_\_ Child often refuses to comply with adult requests or defies authority figures and /or rules.
- \_\_\_\_\_ Child deliberately annoys others.
- \_\_\_\_\_ Child blames others for his/her mistakes – will not admit responsibility.
- \_\_\_\_\_ Child is often touchy or easily annoyed.
- \_\_\_\_\_ Child is often spiteful or vindictive.
- \_\_\_\_\_ Child is often angry or resentful.

For the behaviors listed below, in the space provided at the left, please **check (3)** any behaviors, which apply, **stating when problem(s) identified began:**

- \_\_\_\_\_ Child bullies, threatens or intimidates others.
- \_\_\_\_\_ Child is physically cruel to other people.
- \_\_\_\_\_ Child is often initiates physical fights.
- \_\_\_\_\_ Child is physically cruel to animals.
- \_\_\_\_\_ Child has forced another person into sexual activity.
- \_\_\_\_\_ Child has used a weapon in a fight.
- \_\_\_\_\_ Child has stolen with confrontation of the victim.
- \_\_\_\_\_ Child has deliberately destroyed another’s property.
- \_\_\_\_\_ Child is deliberately fire setting.
- \_\_\_\_\_ Child is often truant from school.
- \_\_\_\_\_ Child stays out at night without parental consent (under age 13)
- \_\_\_\_\_ Child has run away overnight at least 2 times in past. (3 in < year).

For the behaviors listed below, in the space provided at the left, please **check (3)** any behaviors, which apply, **stating when problem(s) identified began:**

Anxiety or excessive worries with inability to control same with –

- \_\_\_\_\_ Feelings of restlessness or “being on edge;”
- \_\_\_\_\_ Easily fatigued;
- \_\_\_\_\_ Difficulty concentrating;
- \_\_\_\_\_ Irritability;
- \_\_\_\_\_ Sleep disturbance – unable to fall asleep or restless sleep;
- \_\_\_\_\_ Muscular tension.

For the behaviors listed below, in the space provided at the left, please **check (3)** any behaviors, which apply, **stating when problem(s) identified began:**

(Also, indicate if the duration has been **MORE** or **LESS** than 1 month.)

- \_\_\_\_\_ Child has experienced or witnessed event in which individual or others felt threatened with death or significant injury.
- \_\_\_\_\_ Child has intense fear, horror, helplessness and/or agitated behavior related to event or trauma.
- \_\_\_\_\_ Child has recurrent ~~intrusive~~ memories of event or trauma.
- \_\_\_\_\_ Child has recurring, distressing dreams related to traumatic event.
- \_\_\_\_\_ Child has sense of reliving traumatic event.
- \_\_\_\_\_ Child has psychological distress to internal or external cues of event, examples and clarification
- \_\_\_\_\_ Child has physiological distress to cues associated with trauma.
- \_\_\_\_\_ Child makes efforts to avoid thought and/or feeling related to event.
- \_\_\_\_\_ Child has inability to recall aspect(s) of event or trauma.
- \_\_\_\_\_ Child has loss of interest in significant activities previously enjoyed.
- \_\_\_\_\_ Child feels detached or separate from others.
- \_\_\_\_\_ Child has problems expressing strong emotions.
- \_\_\_\_\_ Child makes effort to avoid activities, places or people that remind him/her of the trauma.

- \_\_\_\_\_ Child has sense of foreshortened future.
- \_\_\_\_\_ Child has difficulty falling asleep or restless sleep patterns.
- \_\_\_\_\_ Child experiences hypervigilance – feeling a need to be “on guard”.
- \_\_\_\_\_ Child has exaggerated startle response.
- \_\_\_\_\_ Child is irritable or experiences frequent outbursts of anger.
- \_\_\_\_\_ Child has difficulty concentrating.
- \_\_\_\_\_ Child’s symptoms create significant problems with normal functioning.

For the behaviors listed below, in the space provided at the left, please **check (3)** any behaviors, which apply, **stating when problem(s) identified began:**

- \_\_\_\_\_ Child is depressed or irritable most of the day (nearly every day) OR
- \_\_\_\_\_ Child shows diminished pleasure in normally enjoyable activities WITH
- \_\_\_\_\_ Frequent suicidal thoughts and/or previous suicide attempt;
- \_\_\_\_\_ Lack of appetite (weight loss) or overeating (weight gain);
- \_\_\_\_\_ Insomnia or excessive sleep;
- \_\_\_\_\_ Fatigue or decreased level of energy;
- \_\_\_\_\_ Difficulty concentrating or problems making decisions;
- \_\_\_\_\_ Excessive guilt or reported sense of worthlessness;
- \_\_\_\_\_ Agitation or retardation in psychomotor activities as observed by others.

For the behaviors listed below, in the space provided at the left, please **check (3)** any behaviors, which apply, **stating when problem(s) identified began:**

- \_\_\_\_\_ Child has unrealistic or persistent worry about possible harm to family.
- \_\_\_\_\_ Child has excessive unrealistic worry that calamitous event will occur and subsequently separate child and family.
- \_\_\_\_\_ Child frequently refuses to attend school.
- \_\_\_\_\_ Child often refuses to sleep alone.

- \_\_\_\_\_ Child experiences recurring nightmares with themes of separation.
- \_\_\_\_\_ Child has frequent somatic complaints of aches and pains
- \_\_\_\_\_ Child avoids being left alone, and expresses extreme fears regarding same.
- \_\_\_\_\_ Child becomes overly upset if separated from home or major attachment figures.

\_\_\_\_\_  
**Signature of Parent or Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Therapist/**

\_\_\_\_\_  
**Date**