

Child and Family History

|  |  |  |  |
| --- | --- | --- | --- |
| Form completed by: { } Parent | { } Foster Parent | { } Guardian | { } Other : |
| Are you a single parent? { } Yes | { } No |  |  |

Child's Name:

DOB:

Age:

Gender: { } Male { } Female

Grade:

Name of School:

Referred by:

Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number/Sponsor ID Group Number

Card Holders Name/ DOB/ SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City: Zip Code:

Telephone: H W Cell

Parent's Email Address:

Therapist may leave message at : { } Home { } Work { } Cell { } Email (Preferred: ) Race/Ethnicity:

Emergency contact person:

Relationship: Phone #:

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Consent for Child Treatment**

I am the parent/legal guardian of with full legal authority to consent to treatment. I give permission for Trio Rehabilitation, to provide treatment for this child which may include physical and/ or mental health services.

Signature: Date:

Print name: Relationship to child:

Type(s) of service desired. Please check all that apply: \_\_\_ Individual Counseling \_\_\_ ABA (Applied Behavior Analysis) \_\_\_ Speech Therapy \_\_\_ Occupational Therapy \_\_\_ Physical Therapy

Child's presenting issue and/or chief complaint:

Has your child had treatment for these issues in the past? { } Yes { } No Has your child had inpatient mental health treatment? { } Yes { } No

Briefly describe treatment including dates, name of facility/therapist, presenting issues and outcome:

Describe any other behavioral or emotional problems your child is having:

Describe the impact of your child's problems on the family:

Describe your child's strengths and unique qualities:

Is your child currently under the care of a physician or psychiatrist? { } Yes { } No

If yes: Doctor's Name: Phone #

Treatment for:

Is your child currently taking any medications? { } Yes { } No If yes, include the following information: Name of medications Dosage Prescribed by

Does this child have a history of abuse (physical, sexual, emotional, neglect)? { } Yes { } No

If yes, please describe briefly, including dates, location, perpetrators, type of abuse and impact on child/family:

Is there legal action pending related to accusations of abuse? { } Yes { } No

If yes, describe briefly:

Is there any other legal action that may have impacted your child? Please check all that apply:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Current | Past |  | Current | Past |
| Custody |  |  | Visitation |  |  |
| Adoption |  |  | Child Protective Services |  |  |
| Probation |  |  | Other |  |  |

If yes, describe briefly:

**BEHAVIOR CHECKLIST** Please check any of the following behaviors that concern you:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Behavior: | Current | Past | Behavior: | Current | Past |
| Crying, sadness, depression |  |  | Temper outbursts |  |  |
| Loss of enjoyment of usual activities |  |  | Irritability, anger |  |  |
| Expressing a wish to die |  |  | Argues a lot |  |  |
| Bedtime fears, won't sleep |  |  | Disobedience |  |  |
| Has threatened/attempted suicide |  |  | Does things that annoy others |  |  |
| Worries more than others |  |  | Unusual fears or phobias |  |  |
| Panics |  |  | Anxious, nervous |  |  |
| Repeats unnecessary act over and over |  |  | Is overly concerned about things |  |  |
| Has rituals, habits, superstitions |  |  | Twitches or unusual movements |  |  |
| Eats very little/fasts to lose weight |  |  | Gorges or binge eats |  |  |
| Sleepwalking |  |  | Blames others for own mistakes |  |  |
| Withdrawn |  |  | Easily annoyed by others |  |  |
| Nightmares, night terrors |  |  | Swears or uses obscene language |  |  |
| Low self-esteem |  |  | Wanting to run away |  |  |
| Wakes up very early, unable to go back to sleep |  |  | Sneaks out at night |  |  |
| Tiredness, fatigue |  |  | Injures self |  |  |
| Restless sleep, wakes frequently |  |  | Stealing |  |  |
| Trouble going to sleep |  |  | Lying |  |  |
| Sleeps too much |  |  | Hurts animals |  |  |
| Poor appetite |  |  | Destroys property |  |  |
| Under or overweight |  |  | Hurts people |  |  |
| Over-activity |  |  | Drug use |  |  |
| Frequently acts without thinking |  |  | Alcohol use |  |  |
| Doesn't finish things |  |  | Cigarette use |  |  |
| Disruptive |  |  | Sexual problems |  |  |
| Short attention span |  |  | Problems with authority |  |  |
| Daydreams, fantasizes |  |  | Problems with the law |  |  |
| Easily distracted |  |  | Low motivation |  |  |
| Hallucinations |  |  | Vomits intentionally |  |  |
| Bedwetting/daytime wetting |  |  | Soiling (pooping) in pants |  |  |
| Strange or unusual behavioral |  |  | Disorientation |  |  |

**Relationship Development** Check each item that describes your child:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Current | Past |  | Current | Past |
| Prefers to be alone |  |  | Is demanding and bossy |  |  |
| Is alone a lot, but dislikes this and feels lonely |  |  | Fights with others |  |  |
| Is shy |  |  | Bullies others |  |  |
| Has few friends |  |  | Teases a lot |  |  |
| Has many friends |  |  | Plays with younger kids |  |  |
| Plays with “problem kids” |  |  | Plays with older kids |  |  |
| Is picked on a lot |  |  | Poor relationships with peers |  |  |
| Is oversensitive |  |  | Conflict with parents/step-parents |  |  |
| Poor relationships with teachers |  |  | Has difficulty getting along with brothers and sisters |  |  |

**School** Check any area of concern:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Current | Past |  | Current | Past |
| Dislikes school |  |  | Missed many school days |  |  |
| Works hard but does not do well |  |  | Repeated a grade |  |  |
| Unmotivated, refuses to complete work |  |  | Discipline referrals, detentions |  |  |
| Learning problems |  |  | Suspensions (how many? ) |  |  |
| Expulsions (how many? ) |  |  |  |  |  |

If your child has been suspended or expelled, please explain:

**School Environment** Check all that apply:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Current | Past |  | Current | Past |
| Resource classes/special ed. |  |  | Continuation school |  |  |
| Gifted program |  |  | Home study |  |  |
| Speech therapy |  |  | Independent study |  |  |
| Other programs |  |  |  |  |  |

If other programs, please explain:

**Family Stresses** Check all that apply:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Current | Past |  | Current | Past |
| Marital problems |  |  | Housing problems |  |  |
| Marital separation |  |  | Legal issues |  |  |
| Divorce |  |  | Death of a friend |  |  |
| Custody disputes |  |  | Death of a relative |  |  |
| Financial problems |  |  | Death of a pet |  |  |
| Job loss |  |  | Family illness |  |  |
| Parents using alcohol/drugs |  |  | Other stressors: |  |  |

If other stressors, please describe:

**Developmental History** During pregnancy, did mother:

{ } drink { } drugs { } illness { } accident

{ } problems with pregnancy { } problems with labor { } problems with delivery

full term \_\_\_\_\_ NICU stay \_\_\_\_\_ birth weight \_\_\_\_\_

If yes, please describe:

Please check if child is/was delayed in any of the following areas: { } holding head up

{ } turning over { } sitting up { } crawling { } walking alone { } weaning { } feeding self

{ } toilet training { } using single words { } using sentences { } dressing self { } sleeping through night Briefly explain any delays:

**As a baby/toddler, was child:** check all that apply

{ } eating well { } colicky { }head banging { } performing rocking behavior { } clumsy

{ } easy to regulate (sleeping/eating) { } wanting to be left alone { }adaptable to transitions

{ } more interested in things than people { } easy to soothe { } performing daredevil behavior

**Medical History** Indicate if your child has had any of the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Condition | Yes | No | Age | Details |
| Serious Infection |  |  |  |  |
| Convulsions/seizures |  |  |  |  |
| Head injuries |  |  |  |  |
| Other injuries |  |  |  |  |
| Hospitalizations |  |  |  |  |
| Surgeries |  |  |  |  |
| Ear infections |  |  |  |  |
| Poisonings |  |  |  |  |
| Allergies |  |  |  |  |
| Asthma |  |  |  |  |
| Alcoholism |  |  |  |  |
| Drug Use |  |  |  |  |
| Sexual Problems |  |  |  |  |

Does your child have any other medical conditions? { } Yes { } No

If yes, please describe:

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Does your child frequently complain of bodily aches and pains? { } Yes { } No

If yes, please describe:

Does your child miss school because of his/her physical complaints? { } Yes { } No

If yes, please describe:

Does your child have any allergies to medications, drugs or foods? { } Yes { } No

If yes, please describe:

**Family Information:** List all of the people who currently live with the child

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Relationship | Occupation/School and Grade |
|  |  |  |  |
|  |  |  |  |
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Indicate if any family members or relatives have the following:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mother | | Father | | Brother | | Sister | | Other | |
| Problem: | Now | Past | Now | Past | Now | Past | Now | Past | Now | Past |
| Problems with attention, activity or impulse control as a child |  |  |  |  |  |  |  |  |  |  |
| Learning disabilites |  |  |  |  |  |  |  |  |  |  |
| Did not graduate from high school |  |  |  |  |  |  |  |  |  |  |
| Alcohol abuse |  |  |  |  |  |  |  |  |  |  |
| Drug use |  |  |  |  |  |  |  |  |  |  |
| Problems with aggressive behavior as adult or child |  |  |  |  |  |  |  |  |  |  |
| Antisocial behavior (arrests, jail, legal problems, probation, other |  |  |  |  |  |  |  |  |  |  |
| Abuse victim |  |  |  |  |  |  |  |  |  |  |
| Abusive to others |  |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |  |
| Autism |  |  |  |  |  |  |  |  |  |  |
| Intellectual Disability |  |  |  |  |  |  |  |  |  |  |
| Serious illness or surgeries |  |  |  |  |  |  |  |  |  |  |
| Physical Disability |  |  |  |  |  |  |  |  |  |  |
| Tics or unusual movements |  |  |  |  |  |  |  |  |  |  |
| Other mental problems |  |  |  |  |  |  |  |  |  |  |

What are your family supports? (church, friends, clubs etc.)

What are your family strengths?

Additional comments:

Please list any adults who are authorized to drop off or pick up your child from his/her therapy session in the event you or another legal guardian are unavailable:

|  |  |
| --- | --- |
| Name | Relationship to child |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

# I authorize the above named person(s) to drop off or pick up my child from his/her therapy session.

**Child's Name Date of Birth**

**Print Parent/Guardian Name Relationship to child**

**Signature Date**