sunny days therapeutics

CHILD MEDICAL AND MENTAL HISTORY QUESTIONNAIRE

Are there parts of this questionnaire that should not be discussed in front of your child? **Yes** **No**

Date form was completed:_____

Person completing form:_____ Relationship to child:_____ Phone #: _____

CHILD'S INFORMATION:

Child's name:_____ Age: _____ Date of Birth:_____ Sex: M F Other

Last First

Mailing Address:_____

City: _____ State: _____ Zip: _____ Home Phone #:_____

Please list all problems:

REFERRAL INFORMATION:

Please describe as fully as you can, why your child is being brought for therapy. If he/she has had a medical condition that may be contributing to his/her problems, please include what happened, when, what treatment was provided, etc . . .

_____

_____

_____

FAMILY INFORMATION:

	Birth Mother	Birth Father
Name:		
Age:		
Highest grade completed:		
Occupation:		
Home Address:		
Phone Number:		

Status of **parents' relationship**:____Married ____Separated ____Divorced ____Widowed ____Single

How long married? _____ How long divorced? _____ Child's age at divorce: _____

If parents are separated or divorced, who has **custody** of this child? _____

How often does the **other parent** see this child?

___ Weekly or more often _ Once or twice/month ___ Few times/yr. ___ Never

Is this child **adopted?** Yes No If yes, child's age at adoption

Does this child have **other parent(s)/stepparent(s)?**___Yes ____No

If yes, please provide the following information:

	Adoptive Mother or Stepmother or Other (Circle One)	Adoptive Father or Stepfather or Other (Circle One)
Name:		
Age:		
Highest grade completed:		
Occupation:		
Home Address:		
Phone Number:		

This **child is living with**:

____Both parents ____Mother ____Father ____Mother and Stepfather ____Father and Stepmother

____Legal guardian _____Other (please specify)_____

How long has this child been in current living situation? _____

Please list any **other persons** residing in the home:

	Name	Relation to Child
1.		
2.		

Please list all of this child's siblings and their relationship to the child:

Child's Siblings Name	Age	Sex	Relationship Full	Half	Step	Resides in the home?
1._____	_____	_____	___	_____	_____	___Yes ___No
2._____	_____	_____	___	_____	_____	___Yes ___No
3._____	_____	_____	___	_____	_____	___Yes ___No
4._____	_____	_____	___	_____	_____	___Yes ___No
5._____	_____	_____	___	_____	_____	___Yes ___No

Please list any **other persons** residing in the home:

	Name	Relation to Child
1.	_____	_____

Please check the background of each of the following:

Sometimes aspects of background or identity are important in understanding a child. By background or identity, we mean,the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic background, your gender or sexual orientation, and your faith or religion.
In your opinion, are there aspects of your child's ***background or identity*** *that we should know? If yes, please describe these aspects and how it impacts your child's life:* _____
_____
_____

What is the **primary language** spoken in the home?____English ____Spanish Other:_____

Does the child speak a language other than English?___Yes ___No
If yes, what language(s)?_____At what age did the child start speaking this language?_____

What do you **enjoy** most about this child? _____

What do you find most **difficult** about raising this child? _____

Who is mainly in charge of **discipline** in the home? _____

Do all caregivers agree on discipline? _____

Describe discipline techniques: _____

PREGNANCY AND DELIVERY

Mother's age at pregnancy of this child:_____ Father's age at pregnancy of this child:_____

When did prenatal care begin with this child?_____

Mother's health during the pregnancy: Excellent___ Fair___ Poor___

Please check any of the following that the child's mother had during the pregnancy of this child:

___Measles	___Excessive swelling	___Emotional problems
___German measles	___Excessive vomiting	___Injury/accident
___High fever	___Poor nutrition	___Placenta abrupta
___High blood pressure/toxemia	___Abnormal weight gain	___Placenta previa
___Diabetes	___X-rays (what month?) _____	

___**Hospitalizations/surgeries** If yes, please describe: _____

___Took **medications during** pregnancy If yes, please describe _____

___Other complications: Please describe_____

Substances used during pregnancy:

___Cigarettes: If yes, how many?____per (___day____week)

___Alcohol: If yes, how many drinks?____per (___day____week____month)

___Drugs: If yes, please describe type(s) of drug, frequency of use, and when during pregnancy _____

_____

This child was born:____On time____Early ___Late Length of pregnancy: weeks

Type of labor: Spontaneous Induced

Length of labor:_____hours

Type of **delivery**:___Head first ___Breech ___C-section ___Forceps/suction used

___Cord around neck ___Cord presented first___Hemorrhage ___Infant injured during preg.

___Other (describe) _____

This child's **birth weight**: _____ Length of stay in hospital: Mother:____days

Child:_____days

Check any of the following that the child had at birth or during the first week of life:

___Difficulty breathing If yes, describe_____

___Supplemental oxygen If yes, how long?_____

___Feeding problems ___Excess vomiting ___Fever

___Seizures/convulsion

___Jaundice ___Bilirubin lights used ___Drugs/medications needed

___Other complications (describe): _____

DEVELOPMENTAL HISTORY

Are (or were there) any concerns about the development of this child? _____Yes ___No

If yes, explain_____

Describe this child as an infant/toddler (check all that apply):

___Active ___Cuddly ___Sickly ___Colic

___Calm ___Hard to please ___Breathing problems ___Slow to develop

___Easy ___Difficult ___Frequent ear infections ___Rocked self a lot

___Happy ___Cried frequently ___Sleeping problems ___Head banging

___Poor eye contact ___Other problems (specify):_____

Give approximate ages when the child did the following:

Gross Motor

Sat unsupported _____

Crawled/crept_____

Stood unassisted _____

Fine Motor

Walked alone _____

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Picked up small objects _____ Fed themselves ___ Held a crayon _____

Language

Said "mama/dada" _____

Spoke first words _____

Talked in 2-3 word sentences _____

Talked in full sentences_____

Toileting

Bladder trained _____

Bowel trained _____

Has the child received any **intervention** services between the ages of 0-3 years?

Speech-language therapy?___Yes _____No

Occupational therapy? ___**Yes** _____No

Physical therapy? ___**Yes** _____No

SCHOOL HISTORY

Does or did this child attend **Preschool**?____Yes ____No If yes, at what age? _____

Amount of time per day: _____hours_____days/week

Any problems in Preschool? ____Yes ____No If yes, please describe: _____

_____

Has this child received a **Child Find** evaluation?____Yes____No If yes, what were the results?: _____

_____

Did the child receive **intervention services** in preschool?___Yes_____No If yes, please describe: _____

_____

Does or did this child attend **kindergarten**?__Yes ____No

Any problems in kindergarten?___Yes ____No If yes, please describe _____

_____

What **school** is the child attending?_____Grade _____

Has this child ever **repeated** a grade? ____Yes ____No If yes, which grade(s)_____

Has this child **skipped** a grade in school?____Yes ____No If yes, which grade(s) _____

Does or did this child have any difficulty with **math**? _ Yes ___ No If yes, explain: _____

_____

Does or did this child have any difficulty with **reading**? Yes___No If yes, explain:_____

_____

Does or did this child have any difficulty with **spelling/writing**? _ Yes___No If yes, explain:_____

_____

Has this child ever been **tested before** (e.g., special education, intellectual, academic, speech/ language, psychological, developmental) ___ Yes ___ No

If yes, explain: _____

_____

_____

Please select if your child has received any of the following:

Individualized Education Plan (IEP) **Current** **Past** **Never** 504 Plan **Current** **Past** **Never**

If yes, what is (or what was) the primary disability (e.g., reason child is/was eligible)?

____Specific Learning Disorder ____Intellectual Disability ____Traumatic Brain Injury

____Speech or Language Impairment ____Autism ____Emotional Disturbance

____Other Health Impairment

Please circle if your child has ever received any of the following **special education services**:

Speech-language therapy	Current	Past	Never	Social Work/counseling	Current	Past	Never
Occupational therapy	Current	Past	Never	Behavior Intervention Plan	Current	Past	Never
Physical therapy	Current	Past	Never	Other: _____	Current	Past	Never

If currently receiving special education, what is the setting for special education services?_____

_____

____Inclusion setting services only (i.e., all special education provided in regular education classroom)

____Segregated services primarily (i.e., all academic coursework provided in segregated/special education classroom)

____Mixed settings (i.e., some classes in regular education classroom and in segregated/special education classroom)

If mixed, Please list child's classes taught in Inclusion setting:_____

Please list child's classes taught in Segregated setting:_____

MEDICAL HISTORY

Please check any of the following that this child has had and indicate age (year/month)

_____Measles	_____Appetite/weight problems	_____Fainting/dizziness
_____Meningitis or encephalitis	_____Sleep problems	_____Anemia
_____Seizures/convulsions	_____Vision problems	_____Poisoning
_____Diabetes	_____Hearing problems	_____Persistent high fever
_____Head injury/concussion	_____Cardiac problems/hypertension	_____Asthma
_____Headaches/migraines	_____Chronic pain	

Please describe any **serious illness or operations**: Age

_____ _____

_____ _____

_____ _____

Current **medications**: Name Dose/Frequency Prescribed by

_____

_____

_____

_____

_____

_____

_____

_____

Are there any concerns with this child's **physical health**?____Yes ____No

If yes, please describe_____

Who is this child's primary care **physician**? _____

Has this child had a recent **vision** exam? ___**Yes** ____No

Does this child wear corrective lenses? ___**Yes** ____**No**

Has this child had a recent hearing check? ___Yes ____No

Does this child wear hearing aids? ___Yes ____No

Has this child ever had a neurological exam? ___Yes ____No

If yes, neurologist's name: _____

Date of exam:_____Reason for exam: _____

Results: _____

Has this child ever had an **EEG**?____Yes ____No

If yes, when, why, and what were the results? _____

Has this child ever had an **MRI** or **CT**?___Yes ____No

If yes, when, why and what were the results?_____

Cognitive/Behavioral/Social/Mental Health History

Please circle/check if your child **currently** and/or **in the past** has any of the following problems or difficulties:

Academic learning problems	**Current**	**Past**	Unusual beliefs/delusions	**Current**	**Past**
Difficulties learning life skills	**Current**	**Past**	Hallucinations	**Current**	**Past**
Slow mental processing	**Current**	**Past**	Hyperactivity	**Current**	**Past**
Short term memory	**Current**	**Past**	Short attention span	**Current**	**Past**
Long-term memory	**Current**	**Past**	Poor listening skills	**Current**	**Past**
Spatial awareness problems	**Current**	**Past**	Poor concentration	**Current**	**Past**
Gross motor coordination	**Current**	**Past**	Poor organization	**Current**	**Past**
Fine motor coordination	**Current**	**Past**	Distractibility	**Current**	**Past**
Bed wetting	**Current**	**Past**	Poor judgment	**Current**	**Past**
Soiling problems	**Current**	**Past**	Poor temper control	**Current**	**Past**
Poor peer relations	**Current**	**Past**	Poor impulse control	**Current**	**Past**
Prefers to play alone	**Current**	**Past**	Poor frustration tolerance	**Current**	**Past**
Prefers to play with younger children	**Current**	**Past**	Noncompliance	**Current**	**Past**
Repetitive behaviors/tics	**Current**	**Past**	Lying	**Current**	**Past**
Sensory processing difficulties	**Current**	**Past**	Excessive fighting	**Current**	**Past**
Anxiety/fears	**Current**	**Past**	Alcohol/drug abuse	**Current**	**Past**
Depression	**Current**	**Past**	Running away	**Current**	**Past**
Suicidal ideation	**Current**	**Past**	Difficulties with the law	**Current**	**Past**
Self-harm/cutting	**Current**	**Past**	Fire setting	**Current**	**Past**
Eating disorder	**Current**	**Past**	Truancy	**Current**	**Past**

What **activities** does this child enjoy (e.g., sports, hobbies, music, art)? _____

_____

Has this child ever been physically or sexually **abused** or **neglected?**____Yes ____No If yes, please explain:

_____

Has this child ever been removed from the home because of **neglect or abuse?**__Yes_____No If yes, please explain:

_____

Has this child had any unusual, **traumatic** or possibly **stressful events** that you think may have had an impact on his/herdevelopment and current functioning? If yes, please describe the incident. Include the child's age at the time of incident.

_____

_____

Has this child ever been in trouble with the **law?**__Yes ____No If yes, please explain:_____

_____

Has this child ever received **mental health treatment**, such as counseling (either individually or with the family)?

____Yes ____No If yes, please list any past or current treatments, name of counselor, and when this child was treated:

_____

_____

_____

FAMILY HISTORY

Please indicate if any members of this child's family have or have had any of the following (especially siblings, parents and grandparents):

	Relationship to this child
Alcoholism	_____
Anxiety/Phobias	_____
Attention deficit disorder/	_____
hyperactivity Autism Spectrum	_____
Disorder	_____
Bipolar Disorder (manic-depression)	_____
Cerebral palsy	_____
Depression	_____
Drug abuse	_____
Epilepsy (seizures,	_____
convulsions)Explosive temper	_____
Genetic Disorders	_____
Hospitalized for mental illness	_____
Language/Speech problem	_____
Learning Problems/Disorder	_____
MR	_____
Migraines	_____
Neurological Conditions such as stroke	_____
Reading Problem	_____
Schizophrenia	_____
Stuttering	_____
Suicide	_____
Tourette's Syndrome	_____

Please indicate whether any of this child's immediate family members have/had have any other serious medical

Family Member;	**Medical Problem(s)**
_____	_____
_____	_____

Additional Information

Please add any additional comments you think might be helpful.