



**FAMILY MENTAL HEALTH/MEDICAL HISTORY**

We are interested in whether anyone in your family, other than this child, has or has had any of the conditions listed. Please put an X in the column of the family member(s) who have or have had each problem.

	Child's mother	Child's father	Child's brother(s)	Child's sister(s)	Child's grandfather(s)	Child's grandmother(s)	Other: (please specify)
Hyperactive as a child							
Repeated a grade in school							
Speech Problems							
Seizures							
Mental Retardation							
Behavioral Problems in Childhood							
Trouble with the law							
Depression							
Eating Problems							
Anxiety problems							
Schizophrenia							
Other emotional problems							
Drinking problem							
Drug problem							
Serious health problems							
Other serious problems (please specify)							

**EDUCATIONAL HISTORY**

Current School: \_\_\_\_\_

Current Grade: \_\_\_\_\_ School District: \_\_\_\_\_

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

Reading?: \_\_\_\_\_ Spelling?: \_\_\_\_\_ Arithmetic?: \_\_\_\_\_

Does your child have trouble with handwriting? NO YES

Has your child ever repeated a grade? NO YES

If yes, which grade(s): \_\_\_\_\_

What grades does your child typically receive?: \_\_\_\_\_

Has your child ever had an IEP or 504 Plan? NO YES

What, if any, special educational services does your child receive? \_\_\_\_\_

Has your child had special testing in school over the past year or two? NO YES GRADE \_\_\_\_\_

*Please provide copy of report, if possible*

Please check yes or no to the following, as they apply:

Yes No

	Yes	No
Teacher complaints about behavior		
Attendance problems		
Difficulties finishing/turning in homework		
Suspension/Expulsion		
Fighting/confrontational behavior		
Relating to/playing with other children		
Involved in sports, youth groups, or clubs		
Is your child employed?		

If employed, where and how many hours a week? \_\_\_\_\_

**FOR TODAY'S VISIT**

What are your primary concerns regarding your child? \_\_\_\_\_

How serious do you think your child's difficulties are at this time? (please circle)

No Problem Minor Problem Moderate Problem Serious Problem

What do you like about your child? \_\_\_\_\_

Listed below are items about children's behavior. Decide how much concern you have about each area **over the last few months**. Mark your choice by placing an X in the appropriate column to the right of each item.

BEHAVIORAL AREA	No Problem	Some Problem	Large Problem
Eating problems			
Sleeping problems			
Fears or worries			
Speech problems			
Wets or soils self			
Clingy, dependent			
Temper Tantrums			
Many physical complaints			
Clumsy or Poor Coordination			
Socially Immature			
Nervous Twitches or Tics			
Unhappy Child			
Angry Child			
Braggs			
Shyness			
Problems with friends			
Alcohol/Drug use			
Fights with siblings			
Acts without thinking			
Overactive			
Short Attention Span			
Stealing			

Lying			
Perfectionistic			
Not doing what is asked			
Argues			
Whines/cries			
Suicidal Talk or Thoughts			
Likes being alone			
Overweight			
Lacks energy			
Strange Ideas			
Strange Behaviors			
Sexualized Behaviors			
Other (please specify)			
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			