NEUROBLOOM
PSYCHOLOGICAL CLINIC

CHILD PERSONAL HISTORY FORM

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Child's Name:_____

Age: _____ **Date of Birth:** _____

School: _____ **Sex: M F**

Ethnic Background: _____ **Religious Preference:**_____

Referred by:_____ **Address/Phone:** _____

Father's Name:_____ **Age:**_____ **Occupation:** _____

Mother's Name:_____ **Age:**_____ **Occupation:** _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (Parent, Sibling, etc)	Age	Sex	Type (Biological, Step, etc)	Living with you? Yes or No

Problem Description (Please state the problems for which you want help for this child)

Developmental History

Were there any complications with pregnancy or delivery of your child

☐ **Yes** ☐ **No**

If Yes, Please describe:

Did your child have health problems at birth

☐ **Yes** ☐ **No**

If Yes, please describe:

Did your child experience any developmental delays (e.g. toilet training, walking, talking)

If Yes, please describe:

Did your child have any unusual behaviors or problems prior to age 3?

☐ **Yes** ☐ **No** ☐ **Not Sure**

If Yes, please describe:

Has your child experienced emotional, physical or sexual abuse

☐ **Yes** ☐ **No** ☐ **Not Sure**

If Yes, please describe:

Emotional/Behavioral/Chemical Issues (Has your child recently or currently experiencing the following)

CONCERN	YES	NO	CONCERN	YES	NO
Recent Suicidal thoughts			Difficulty sleeping		
Suicide plans			Depression		
Suicide attempts			Loneliness or hopelessness		
Self-inflicted injury behaviors			Crying often		
A tendency to be shy or sensitive			Frightening dreams or thoughts		
A strong dislike of criticism			Often annoyed by little things		
A frequent loss of temper			Difficulty completing tasks		
Difficulty expressing feelings			Violent or destructive behavior		
Nervousness, anxiety or worry			Difficulty remembering		
Difficulty relaxing			Difficulty concentrating		
Difficulty making decisions			Mental confusion		
Difficulty making friends			Difficulty with eating		

Has your child ever been in court or picked up by the police?

☐ **Yes** ☐ **No**

If Yes, describe:

Do you think your child has tried cigarettes, sniffing, alcohol or drugs?

☐ **Yes** ☐ **No**

If Yes, describe:

How many hours of screen time (Computer, Video Games, TV etc) does your child engage in daily:____

Peer Relations

Is your child socially:

☐ **Outgoing** ☐ **Shy** ☐ **Depends on the situation**

Has your child experienced bullying?

☐ **Yes** ☐ **No**

Is your child involved in any organized social activities (eg. Sports, Scouts, Music etc)?

☐ **Yes** ☐ **No**

List Activities:_____

School History

Has your child even been held back a grade?

☐ **Yes** ☐ **No**

If Yes, what grade and what was the reason you chose to hold your child back:

What are the grades your child receives at school? _____

Describe your child's academic issues, if any.

Are there any behavior problems at school?

☐ **Yes** ☐ **No**

If Yes, please explain:

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COUNSELING HISTORY

Has your child been diagnosed by a professional as having developmental delays and/or learning problems?

☐ **Yes** ☐ **No**

If Yes, please provide details

Has your child previously seen a counselor?

☐ **Yes** ☐ **No**

If Yes, please provide details

Approximate dates of Counseling: _____

Has your child been prescribed meds?

☐ **Yes** ☐ **No**

If Yes, please provide details

Medical History

In general, this child's health has been:

- Excellent (is rarely sick, when sick recovers quickly)
- Good (is not often sick or injured, illnesses are fairly short-lived)
- Fair (is frequently sick or injured, illnesses often linger or recur)
- Poor (is chronically ill)

Name of Physician: _____

Name of Facility: _____

Medications the child is currently on _____

Please describe any medical issues:

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Child's Personality and Behavior

	Often True	Sometimes True	Seldom True	Cannot Say
Outgoing				
Self-Confident				
Seems Happy				
Friendly				
Enjoys new experiences or activities				
Even disposition or steady moods				
Expresses feelings				
Affectionate				
Follower				
Independent				
Leader				
Trouble eating				
Kind or sympathetic to others				
Shares				
Can Compromise				
Follows rules easily				
Is forgiving				
Stands up for self when appropriate				
Tolerates criticism				
Recovers easily after disappointment				
Sucks thumb				
Cries often				
Loud				
Is appropriately cautious				
Creative				
Good Sense of humor				
Other_____				

Describe any of the behaviors that you consider to be a cause of concern to you about your child?

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<u>This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.</u>

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Reviewing Therapist

Signature/Credentials: _____ Date: _____