3-C Family Services, P.A.

Complete psychological care for children and families

CHILD SUPPLEMENTARY INFORMATION

(Ages 0 – 17)

To be completed by child's parent/guardian

Child's Full Name: ______________________________________ Date of Birth: _______________
(MM/DD/YYYY)

MEDICAL HISTORY:

Were there any problems with pregnancy or delivery? ____________If so, please describe:

Was the child exposed to any medications, toxins, alcohol, or cigarettes before birth? ____________
If so, please describe.

Was your child born on time? __________ Birth weight:_______________APGAR scores:_________

Were any birth defects identified? ________________

Were there any problems in the first few days of life? _______________

Has your child had frequent ear infections? _________________

Does your child have any illnesses for which he/she is currently being treated?_________If so, please describe nature of illness and treatment:

Please list any surgeries your child has had and when they were performed:

Has your child ever had a seizure, head trauma, or loss of consciousness?____________If so, please describe.

Has your child ever had a CT scan, EEG, or MRI? ________________If so, please describe:

Has your child ever been hospitalized? ____________If so, please describe where, when and for what reason:

Has your child ever been seen in the emergency room? __________If so, please describe.

If your child is female, has she begun to have menses, if so, are they regular? ______________

Has your child been evaluated for any type of heart condition? _______ If so, please describe:

Per the Health Insurance Portability and Accountability Act (HIPAA) this information is strictly confidential.

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CHILD SUPPLEMENTARY INFORMATION
-CONTINUED-

MEDICAL HISTORY CONTINUED:

Date of the most recent physical exam: _______________

Is your child's vision within normal limits (without glasses)? ____________

Is your child's hearing within normal limits? ________________

Please list any medication and doses your child is taking currently including over-the-counter preparation, herbal preparations and vitamins.

Is your child allergic to any medications? ___________If so, please list the medication and the reaction:

Do you believe your child uses recreational drugs or alcohol? _________ If so, please describe:

PLEASE CHECK ANY SYMPTOMS BELOW THAT YOU ARE CURRENTLY HAVING:

___ weight changes
___ fever
___ headaches
___ changes in vision or hearing
___ chest pain or heart palpitations
___ dizziness
___ fainting
___ trouble breathing
___ stomach discomfort
___ nausea or vomiting
___ diarrhea

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___ constipation
___ problems with urination
___ irregular menstrual cycles (if applicable)
___ muscle or joint pain
___ numbness or weakness
___ hair loss
___ easy bleeding or bruising

DEVELOPMENTAL MILESTONES

At what age did your child:

Wean from breast? ______________________From bottle? __________________________
Walk? ____________________Use two-word sentences? __________________________________
Toilet train? __________________________________

Were there any delays in development (speech, motor) noted?

Please describe what your child was like between ages 0 and 4 with respect to the following attributes:

Ability to soothe self when upset:

Showed initiative and curiosity:

Seemed to be dependent on external rewards to achieve behaviors desired by parents?

Avoiding harm:

Activity level:

EDUCATIONAL HISTORY

Please list all schools attended and for which grades, grades on most recent report card, and any teacher comments:
Current School:

Has your child ever repeated or skipped a grade? _____________If so, please describe.

Has your child ever had an IEP (Individualized Educational Plan)? ___________ Starting in which grade? _________

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Please list any special services your child receives (tutoring, speech/language, advanced/gifted classes, occupational therapy)

Have any expulsions or suspensions occurred? ___________ Please describe.

Has your child ever had educational testing to identify learning problems or giftedness? If so, please list where, when, and with what result? Please bring any reports of evaluation to your appointment

FAMILY HISTORY

Please list any blood relative with the following: (Specify whether on maternal side or paternal side of the family)

Substance abuse: ______________________________

Attention deficit: ______________________________

Learning problems or mental retardation: ______________________________

Depression: ______________________________

Bipolar disorder (manic-depression):______________________________

Schizophrenia: ______________________________

Autism: ______________________________

Obsessions/Compulsions: ______________________________

Panic: ______________________________

Eating disorders: ______________________________

Other Anxiety: ______________________________

Suicide: ______________________________

Diabetes: ______________________________

Cancer (specify type): ______________________________

Hypertension or heart disease: ______________________________

Thyroid disease: ______________________________

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Kidney disease: ____________________

Migraines: ____________________

Tics: ____________________

Genetic syndromes (please specify): ____________________

Neurologic disorders (Parkinson's, multiple sclerosis, Alzheimer's, etc.): ____________________

Epilepsy: ____________________

Sudden Unexplained Death before age 40: ____________________

SOCIAL HISTORY

Please list name and ages of all persons living in the home: If child lives at more than one location, please list separately:

-
-
-
-
-
-

How well does your child do socially?

Which of the following best describes your child's interactions with peers:

No friends ____________
Few friends ___________
Loses friends __________
Mean, aggressive ______

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-CONTINUED-

Too shy/timid _________
Bossy ________________
Chooses friends who get into trouble ___________

Other ____

Please list other cities where your child has lived and at what ages:

Your child's extra-curricular activities:

Any legal or custody issues:

Any stressful issues your child has had:

PREVIOUS TREATMENT

Is this your first mental health consultation? _________ If not, please list the following where applicable:

Previous evaluations (evaluator, date of evaluation, recommendations):

Previous psychotherapy (therapist, dates of treatment):

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Previous medication trials (name of medications, dose, how long the medication was taken): *Note: If uncertain, this information may be obtained from your pharmacy where prescriptions were filled.*

Name of Medication	Maximum Dose	Dates Prescribed (from-to)	Reason for Stopping

Previous psychiatric hospitalizations (hospital name, dates of hospitalization, treatment received during the hospitalization):

Please contact previous provider to request any pertinent medical records and have them faxed to your 3-C Family Services' clinician prior to your first appointment so they may be reviewed prior to your consultation.

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