COMMUNITY PSYCHOLOGICAL CONSULTANTS
9102 North Meridian Street, Suite 400
Indianapolis, IN 46260
(317) 574-1785
Fax: (317) 574-1786

CHILD INFORMATION FORM

Please complete the following form. Use additional paper if necessary to respond to questions or provide additional documentation.

Patient Information:

Name: ____
Gender: ________________ Age: ________________ Date of Birth: ________________
Grade: ________________ School: ____________________________________

Mother's Information:
Name: ____
Address (including zip code): ______________________________
____
Home Telephone Number (including area code): ____________________
Occupation: ____
Years of Completed Education or Degree: ________________________
Work Telephone Number (including area code): ____________________
Marital Status: __________________ Number of Marriages: __________________
If Remarried or Living with Another Adult, Name, Years of Education, and Occupation of Current Partner: ______________________________
____

Father's Information:
Name: ____
Address (including zip code): ______________________________
____
Home Telephone Number (including area code): ____________________
Occupation: ____
Years of Completed Education or Degree: ________________________
Work Telephone Number (including area code): ____________________
Marital Status: __________________ Number of Marriages: __________________
If Remarried or Living with Another Adult, Name, Years of Education, and Occupation of Current Partner: ______________________________
____

Child Residence Information:

List the names and relationship of persons with whom the child primarily resides:

If parents are not living together, please describe custody and visitation arrangements:

If parents are not living together, please indicate how old the child was when separation and/or divorce occurred:

Siblings:

Please list the name, sex, age, type of relationship (full, half, step) and primary residence of any sibling:

Name	Sex	Age	Relationship	Primary Residence

Presenting Problem:

Please describe your child, including concerns and strengths.

Please indicate what specific problems or concerns related to your child led you to seek evaluation and/or consultation at this time.

When did you first have these concerns? ____
____

By seeking evaluation and/or consultation, what changes or outcomes regarding your child do you hope for? ____
____
____
____
____
____

Has your child participated in a previous psychological or educational evaluation? When, with whom, and for what reason(s)? What conclusions were reached? Do you feel that these conclusions were valid? Please provide copies of all evaluations. _______________
____
____
____
____

Developmental History:

If your child was adopted, please indicate the age at adoption, describe what you know about your child's life prior to adoption, and answer any additional questions for which you have available information. ____
____
____
____
____
____

Briefly describe the pregnancy. Were there any problems or complications during the pregnancy? Was pregnancy with full term? (If not, indicate length of the pregnancy.)
____
____
____

Were any complications noted during labor or delivery? Was this child delivered vaginally or by Cesarean section? (Please describe any complications.)
____
____
____
____

Child APGAR (if known): ______________

Birth Weight: _______________

Please describe the health of your child at birth, including any complications or need for treatment. ____
____
____

____

Did your child leave the hospital within a normal period of time? (If not, please explain)
____
____
____
Describe your child as an infant (cuddly, difficult, colicky, active, etc.)? _____________
____
____
____
____

At what age did your child:

- Smile in response to those around him or her? __________
- Roll over from stomach to back? __________
- Crawl? __________
- Walk without holding on? __________
- Use single words? __________
- Use two to three word sentences? __________
- Remain dry during the day? __________
- Remain dry at night? __________

Has your child <u>not</u> attained normal development in any domain? Has your child ever lost previously gained skills? (Please explain.) ___________________________________
____
____
____
____
____

Please indicate (by checking it) whether your child has evidenced any of the following:

- Problems with Feeding or Eating __________
- Temper Tantrums __________
- Excessive Hitting __________
- Biting __________
- Self-Injurious Behaviors __________
- Social Withdrawal __________
- Rocking __________
- Shyness __________
- Problems with Sleep __________
- Excessive Fears __________
- Excessive Activity Level __________
- Difficulty Sitting Still __________
- Difficulty Paying Attention or Focusing __________
- Difficulty Completing Schoolwork _________
- Disorganization _________
- Repetitive or Compulsive Behaviors __________

Hand flapping or Toe-walking ___________
Repetitive Vocalizations ___________
Poor Social Skills ___________
Defiance ___________
Lying __________
Excessive Rule-Breaking ___________
Cutting __________
Suicidal Thoughts __________
Suicidal Attempts __________
Trouble with the Law ___________
Running Away __________
Truancy __________
Problems with Drugs or Alcohol ___________
Trauma _____________
Sexual Molestation or Abuse _________
Sexual Acting Out _________
Other_________(Please indicate below)

If you have checked any of the above behaviors, please explain the behaviors and at what age behavior was observed: ____
____
____
____
____
____
____

Has your child received any early intervention services (speech-language, occupational, physical, developmental, etc.)? If so, please describe the history of these services.
____
____
____
____

Childcare History:

Please indicate who has cared for your child since birth to the present when you are not home or when your child is not in school. _______________________________________
____
____
____

What problems, if any, have any problems been noted in childcare? _________________
____
____

Educational History:

Please indicate where (if different from the previous year) and what problems (if any) were noted, including learning problems, behavioral problems, referral for special services, suspensions or expulsions, retention, or other problems? Preschool and/or Pre-kindergarten (including age at attendance):

Kindergarten (including age at attendance):

First Grade:

Second Grade:

Third Grade:

Fourth Grade:

Fifth Grade:

Sixth Grade:

Seventh Grade:

Eighth Grade:

Ninth Grade:

Tenth Grade:

Eleventh Grade:

Twelfth Grade:

Has your child ever been retained in a grade? ______________________________
Has your child ever received special education services? ______________________
If so, for what reason? ____
Has your child ever received tutoring outside of school? ______________________
Does your child like school? ____

Medical History:

Has your child participated in a previous psychological evaluation? When, with whom, and for what reason(s)? ____
____
____

Has your child participated in previous counseling? When, with whom, and for what reason (s)? ____
____
____

Does your child have any current medical problems? Please explain. ______________
____
____
____
____

Does your child have a history of any medical problems? Please explain. ___________
____
____
____
____

Please indicate what medications, including dosage and time of administration, your child is currently taking on a regular basis, why your child is taking hat medication, and who prescribes it.____
____
____
____

Has your child ever been hospitalized? Please explain. _________________________
____
____
____

Has your child ever had surgery? Please explain. ____________________________
____
____

Child's Physician (Name, Address, Phone Number): ______________________
____

Has your child's vision been tested recently? Results? _________________________
____

Has your child's hearing been tested recently? Results? ________________________
____

Has your child been evaluated by an occupational therapist? Results?
____

Interests:

Does your child participate in any sports activities? Please describe. ________________
____
____
____
____

What are your child's favorite activities, hobbies or interests? ______________________
____
____
____
____

Does your child participate in any club or other organization on a regular basis? If so, what clubs or organizations? ____
____
____

What special skills or talents does your child have? ______________________________
____
____
____

Extended Family History:

Please indicate (and explain briefly) if any extended family member (blood relation) has or had problems in any of the following areas:
Cognitive Impairment/Mental Retardation: ___________________________________
Autism :____
Learning Disability (problems with reading, writing, spelling, math): ______________
____
Attention Problems: ____
Problems Completing School: ____
Behavior Problems: ____
Strong Temper: ____
Anxiety or Worry: ____
Shyness: ____
Obsessions or Compulsions: ____
Panic Attacks: ____
Excessive Fears or Phobias: ____
Depression: ____
Bipolar or Cyclical Depression: ____
Suicide (attempts or completed suicide): ___________________________________
Hallucinations or Delusions: ____
Alcohol or Drug Problems: ____

Trouble with the Law: ____
Other: ____

What family stressors may impact (or have impacted) on your child's current functioning. Please explain. ____

Any Additional Information:

Please provide any additional information that may be helpful in understanding your child's needs. ____