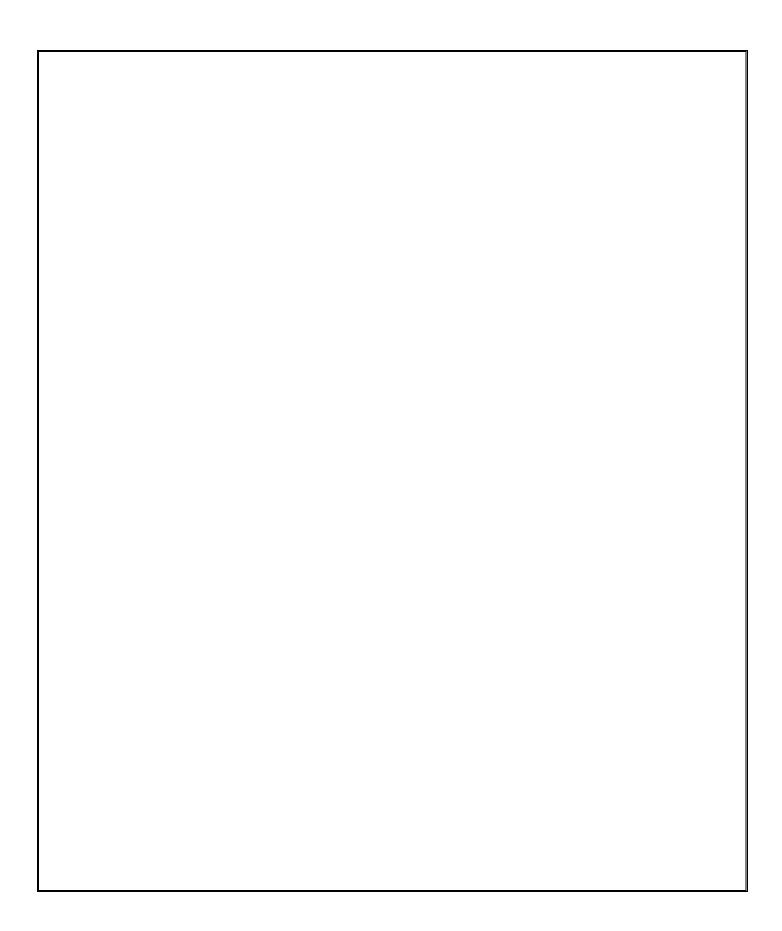
	CHILD HIS	TORYF	ORM	
Instructions: The follow	owing form is to assis	t me in gaining	information about y	our child's
history and current reability. Don't worry a are fine.	eason for seeking help	o. Answer all qu	estions to the best of	f your
Child's Last Name:	First Na	ame:	Middle Initial:	
Today's Date:/	Birth Date:		Age:	
Completed by:				

CHILD HISTORY FORM Please give a brief description of any problems your child currently has for which you feel you need help. What are your child's strengths?

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Please give the ages and relationship of persons in your child's immediate and extended family (Parents, siblings, grandparents, aunts /uncles, first cousins). Opposite each name, list any problems you are aware of such as psychiatric, behavior, alcohol, drugs, etc.

Relationship	Age	List any problems you know of:



Past School History
Please give a brief summary of what your child's academic and social experience in school has been like. How did they get along with teachers? What were their grades like? How did they get along with other children? Friends?
Family Relationships
Briefly describe what your household was like when your child was growing up. Describe what your current family relationships are like.

Madiaal III-I-			
Medical History			
Describe any serious illnesses,	accidents, diseases or	medical conditions of whi	ch you are aware.
Any history of chest pain, pal	pitations, murmurs, fai	nting, or postexercise sym	ptoms? Describe.
Any family history of early he	art disease (before age	30)?	
Current Medications List any medications currently medications.	taking, with the dosag	ge. Include both prescription	on and nonprescription
Name of Med	Name of Medication Why Taken		
Past Medications List all psychiatric or neurolog	cical medications taker	in the past.	
Name of Medication	Why Taken	Why Stopped	When Taken

Please note any other information about your child and your family that you think might be helpful in understanding their problems.

B.E.A.R.S. Sleep Screen			
Bedtime: Does the child resist bedtime or have delayed sleep onset?			
Excessive Daytime Sleepiness: Is the child difficult to awaken in the morning? Does the child seem drowsy or overtired during the day?			
Awakenings: Does the child awaken frequently or for prolonged periods during the night or too early in the morning?			
Regularity, pattern, & duration of sleep: What time does the child go to bed and wake up? Schooldays and weekends? How much sleep do they typically get?			
Snoring: Does the child snore frequently and loudly?			

