CHILD HISTORY FORM

Instructions: The following form is to assist me in gaining information about your **child's** history and current reason for seeking help. Answer all questions to the best of your a**bility. Don't worry about spelling or n**eatness; brief, telegraphic sentences or phrases are fine.

Child's Last Name:_____ First Name: _____ 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?

Family

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.

Medical History

Describe any serious illnesses, accidents, diseases or medical conditions of which you are aware.

Any history of chest pain, palpitations, murmurs, fainting, or postexercise symptoms? Describe.

Any family history of early heart disease (before age 30)?

Current Medications

List any medications currently taking, with the dosage. Include both prescription and nonprescription medications.

Name of Medication	Why Taken

Past Medications

List all psychiatric or neurological medications taken 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?