Assurance Counseling, LLC
I.D.#________________________

CHILDREN'S HISTORY FORM

Parent/Guardian to complete for young children:

Child's Name: ____ **Date of Birth**_____________

Name of adult completing form: _________________________________ **Relation:** ______________________

FAMILY AND DEVELOPMENTAL HISTORY
CURRENT HOUSEHOLD

	MOTHER	FATHER	STEP-PARENT	OTHER ADULTS
NAME				
DATE OF BIRTH				
DATE OF MARRIAGE(S)				
DATE OF DIVORCE(S)				
RACE				
CURRENT EMPLOYER				
HOW LONG				
INCOME				
OCCUPATION (HIGHEST GRADE COMPLETED)				

Names and ages of brothers and sisters living at home: ____

____

Names and ages of brothers and sisters living elsewhere: ____

____

With whom are they living? ____

Who supports this child? ____

LIVING ARRANGEMENT:
How many residences has child lived in since birth? ____

Towns or cities these residences have been located in? ____

Does child share a room with anyone else? No ☐ Yes ☐ Shares with: ______________________________

Sleeps in the same bed with roommate? No ☐ Yes ☐

DEVELOPMENTAL HISTORY
BIRTH:

Was this child Planned ☐ Unplanned ☐ Adopted ☐ If adopted, what age adopted:__________________

Length of pregnancy: _________________months Length of labor __________________hours

Was pregnancy easy? No ☐ Yes ☐ Premature? No ☐ Yes ☐ If premature, how early:_________________

Type of delivery: Spontaneous ☐ Induced ☐ Forceps ☐ Caesarean ☐

Was the infant Head first ☐ Feet first ☐ Breech ☐

Did mother receive any medication during delivery? No ☐ Yes ☐ What kind: _________________________

Was it necessary to give infant oxygen? No ☐ Yes ☐ How long:____________________________________

Did infant require blood transfusion? No ☐ Yes ☐ X-ray? No ☐ Yes ☐ EEG No ☐ Yes ☐

Did infant receive any medication? No ☐ Yes ☐ If yes, what kind? _______________________________

INFANCY:
During the first two weeks, did the infant show any of the following conditions (check all that apply):

Appear yellow ☐ Blue lips ☐ Difficulty breathing ☐ Convulsions ☐ Twitching ☐
Vomiting ☐ Irritable ☐ Slow in responding ☐ Deformed ☐ Very high fever ☐

As a baby, was your child breast-fed? No ☐ Yes ☐ If yes, how long? _____________________________

As a baby, did your child fee well? No ☐ Yes ☐ If no, what was the problem? ______________________

____

Any problems with Diarrhea☐ Constipation☐ Colic☐ Please specify:_____________________________

____

For how long? ____

Any problems with Sleep ☐ Head banging ☐ Thumb sucking ☐ Teeth grinding ☐ Temper tantrums ☐

If yes, please describe: ____

____

When did your child stand alone? ____________ Walk? _______________ Use words __________________

Speak in sentences? __________________ If there were any problems, please describe: _______________

____

When was your child toilet trained: Bladder—day _______ night _____________ Bowels ___________________

Any problems with toilet training? No □ Yes □ If yes, please describe ________________________________

____

SCHOOL AGE

Did your child attend a preschool/day care program? No□ Yes□ If yes, what age(s)_____________________

What is your child's current grade level? 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ 11□ 12□

Recent grades: A□ B□ C□ D□ E□

Has there been a change in grades in the past 6 months? No □ Yes □ If yes, was change Down□ Up□

Has your child ever been in a special education program? No□ Yes□ What grade(s): ___________________

What type of special education program? Learning Disabled □ Emotionally□ Impaired□ Resource Room□

Has your child ever received any special educational help: No□ Yes□ If yes, when______________________

What subjects____

Has your child ever been suspended from school? No□ Yes□ What grade(s) ____________________________

Please describe suspension(s)____

Has your child ever been expelled from school? No□ Yes□ What grade(s) ______________________________

Please describe expulsion(s)____

ADOLESCENCE:

If your child is a teenager, what physical changes have you noticed? _____________________________________

____

Have you noticed a change in your child's attitude towards:

School Family Friends Recreational Activities No□ Yes□ If yes, please describe: ________________________

____

Does your teenager have a paying job? No □ Yes □ If yes, where? _____________________________________

How many hours per week? ___________________ What future plans does your teenager have? _____________

____

DRINKING HISTORY:

Age at time of: First drink_____________ First intoxication_____________ Recognition of problem____________

Drink preference(s): ____

Quantity: ____ Frequency: _________________________________

DRUG HISTORY: (List all drugs used)

Type of drug used				
Age at time of first use				
Quantity				
Frequency				

Chemical Dependency Treatments:

Inpatient/Outpatient/Residential	**Facility**	**Dates**

Family Use of Alcohol, other drugs (include mother, father, step-parents, siblings)

Relationship	**Type**	**Quantity**	**Frequency**

Has any parental figure ever undergone treatment or received help for an alcohol or drug problem?

No □ Yes □ If yes, who____

When? ____________________________ **Where**____________________________________

PREVIOUS PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Has this child ever been seen for emotional problems? No □ Yes □ If yes, when ____________________

Whom____________________________________ **Where** ______________________________

Have other family members had emotional problems? No □ Yes □ If yes, who____________________

Please describe: ____

Has this child ever lived away from home because of emotional problems or family problems? No □ Yes □

If yes, please explain ____

Any history of Neglect□ Emotional Abuse□ Physical Abuse□ Sexual Abuse□ Sexual perpetration□

If yes, please describe: ____

Protective Services involvement? No □ Yes □ If yes, please describe:

____

____

____

____

Has this child ever been in trouble with the court and/or police? No □ Yes □ If yes, please describe: ______

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