Fresh Start for the Mind, LLC
www.freshstartmind.com
Phone: (404) 808-1161

5400 Laurel Springs Parkway, Ste. 802
Suwanee, GA 30024

157 Burke Street, Ste. 119
Stockbridge, GA 30281

CHILD & ADOLESCENT HISTORY FORM

Person Filling Out This Form: _____ Relationship to Child: _____

Child's Name _____ Today's Date:_____

Birth Date _____Age _____ Sex _____ Ethnicity _____

School _____ Grade _____

Home Address _____ City _____ Zip _____

Parent Home / Cell Phone_____ Parent Work Phone _____

Parent Email_____

Emergency Contact: Name _____ Phone_____Relationship_____

Who referred you? _____

Siblings, parents, and other person(s) in the home (use back of page if needed):

Name:	Age:	Relationship to Child:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is any language other than English used at home? _____If yes, what language?_____

If parents are divorced, who is the custodial parent? _____

What is the frequency of visitation with non-custodial parent? _____

Parent address if different from the child (who resides there)? _____

_____

Please give a statement of your concerns and any concerns expressed by teachers or others.

_____

_____

_____

Child History Form

DEVELOPMENTAL HISTORY

PREGNANCY

Duration of pregnancy: _____

Medications taken during pregnancy: _____

Did any of the complications listed below occur during pregnancy?

Threatened miscarriage _____ Infection or illness _____ Toxemia/Swelling _____

Smoking during pregnancy _____ Alcohol during pregnancy _____

Drugs during pregnancy _____ Indicate specific drug and how often:_____

Describe alcohol consumption or use of drugs by the father prior to conception: _____

_____

Other pregnancy complications: _____

DELIVERY

Birth Weight: _____ lbs. _____oz. **Duration of labor:** _____ hours

Type of labor:
Spontaneous _____
Induced _____

Type of delivery:
Vertex (normal) _____
Breech _____
Cesarean _____

Forceps Used:

High _____
Mid _____
Low _____

Complications:

Cord around neck _____
Cord presented first _____
Hemorrhage _____
Infant injured _____
Other _____

Respiration: Immediate _____ Delayed _____ **Cry:** Immediate _____ Delayed _____

If delayed, how long? _____ If delayed, how long? _____

POST DELIVERY PERIOD (While in the hospital)

Jaundice _____ Cyanosis (Turned blue) _____ Incubator care _____ If yes, number of days: _____

Birth defects _____ If yes, specify: _____

Total number of days baby was in the hospital after the delivery: _____

Describe other problems not listed:_____

_____

DEVELOPMENTAL MILESTONES

Record the age your child reached the following developmental milestones. If you cannot recall the age, check *early*, *normal, or late* to indicate when your child achieved each skill. Please use the provided age ranges as a guide.

	Normal Age Range	**EARLY**	**NORMAL**	**LATE**
Sat without support	*5-8 months*			
Crawled	*8-10 months*			
Stood without support	*9-12 months*			
Walked without assistance	*12-14 months*			
Spoke first words besides “ma-ma” & “da-da”	*7-12 months*			
Spoke in phrases	*1-2 years*			
Spoke in sentences	*2-3 years*			

Child History Form

	Normal Age Range	**EARLY**	**NORMAL**	**LATE**
Rode tricycle	*2-3 years*			
Bowel trained, day	*2½ -3 years*			
Bladder trained, day	*2½ -3 years*			
Bowel trained, night	*3-4 years*			
Bladder trained, night	*3-4 years*			
Buttoned clothing	*3-4 years*			
Named colors	*3-4 years*			
Said alphabet in order	*3-4 years*			
Tied shoelaces	*5-6 years*			
Began to read	*5-6 years*			
Rode bicycle without training wheels	*6-8 years*			

Any concerns about your child as an infant/toddler (seeing, hearing, other sensory, social interactions, learning, sleeping, eating)?

_____

_____

MEDICAL HISTORY

Pediatrician: _____

Is your child in good health? Yes _____ No _____ If no, explain: _____

Please indicate if your child's history includes any of the following:

	AGE	**REMARKS** (Comment on any complications, unusual results, and/or the degree and duration of fever.)
SLEEP PROBLEMS		
EYE/VISION PROBLEMS		
FREQUENT EAR INFECTIONS		
DIABETES		
MEASLES		
SCARLET FEVER		
RHEUMATIC FEVER		
MUMPS		
PNEUMONIA		
HIGH BLOOD PRESSURE		
FREQUENT HEADACHES		
CHRONIC COLDS		
ALLERGIES		
ASTHMA		
TONSILLECTOMY		
ADENOIDECTOMY		
BLACKOUTS		
GLANDULAR DISTURBANCES		
EXTREME FATIGUE		
HEAD INJURIES		
CONVULSIONS/SEIZURES		
SICKLE CELL		
OTHER		

Describe any surgery or hospitalization the child has had: _____

_____

Describe any other serious illnesses, accident, falls, or deformities not already mentioned: _____

_____

Child History Form

Medication prescribed for child:

MEDICATION:	DOSAGE:	REASON/CONDITION:	*Does the medication seem to help?*

How is your child's sleep? _____

How is your child's appetite? _____

COORDINATION

Rate your child on the following skills (*Check Above Average, Average, or Below Average.*):

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Walking	_____	_____	_____
Running	_____	_____	_____
Throwing	_____	_____	_____
Catching	_____	_____	_____
Shoelace tying	_____	_____	_____
Buttoning	_____	_____	_____
Handwriting	_____	_____	_____
Athletic abilities	_____	_____	_____

ACADEMIC

Rate your child's academic learning. (*Check Above Average, Average, or Below Average.)*

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Preschool/PreK	_____	_____	_____
Kindergarten	_____	_____	_____
Elementary Years	_____	_____	_____
Current School Year	_____	_____	_____

Has your child had trouble with: Reading _____ Math _____ Spelling _____ Writing _____

Describe any academic problems: _____

_____

Has your child ever been retained or had to repeat a grade? _____ If yes, which grade(s)? _____

Has your child ever received special or remedial services in school (IEP, 504 Plan, SST, RTI, Tutoring, Remedial Classes, Speech Therapy, OT, Counseling)? _____ If yes, describe: _____

_____

Please list the schools your child has previously attended:

SCHOOL	CITY	STATE	DATES ATTENDED

1. _____

2. _____

3. _____

4. _____

Child History Form

SOCIAL HISTORY

CONDUCT

Rate your child's school behavior. (*Check Above Average, Average, or Below Average.*)

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Preschool/PreK	_____	_____	_____
Kindergarten	_____	_____	_____
Elementary Years	_____	_____	_____
Current School Year	_____	_____	_____

Has your child exhibited any of the following:

	YES	*NO*
Discipline problems at school	_____	_____
Discipline problems at home	_____	_____
Suspended from school	_____	_____
Involved with juvenile court	_____	_____
Drug or Alcohol Use	_____	_____

If yes to any of the above please explain: _____

_____

How does your child get along with teachers? _____

PARENT RELATIONSHIP

Circle one: Parents are: Married Divorced Separated How long? _____

Please describe any significant changes in your family or home that may have affected your child: _____

_____

_____

MENTAL HEALTH HISTORY

Has your child been diagnosed with any mental health disorder(s)? _____

Has your child previously received therapy or counseling? _____

Therapist name _____ Dates in therapy _____

Therapist name _____ Dates in therapy _____

Has your child had a psychological evaluation? _____

If yes, please explain when, reasons, and outcome _____

_____

Has your child ever been hospitalized for psychiatric reason? _____

If yes, please provide place, dates, and reasons _____

_____

Psychiatrist (if applicable): _____

Any history of suicidal thoughts or attempts?_____

Any history of self-injurious behaviors (i.e., cutting, biting)?_____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms that are currently present)
0= This symptom is not present at this time
1= Mild impact on quality of life and/or day-to-day functioning
2= Moderate impact on quality of life and/or day-to-day functioning
3= Significant impact on quality of life and day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Alcohol problems	0 1 2 3	Stays out late/runs away	0 1 2 3	Sadness	0 1 2 3
Drug problems	0 1 2 3	Truant from school	0 1 2 3	Low self-esteem	0 1 2 3
Social/relational issues	0 1 2 3	Steals	0 1 2 3	Thoughts of death	0 1 2 3
Academic problems	0 1 2 3	Inattentive	0 1 2 3	Threats of self-harm	0 1 2 3
Physically aggressive	0 1 2 3	Fidgets/squirms	0 1 2 3	Sleep problems	0 1 2 3
Verbally aggressive	0 1 2 3	Fails to finish things	0 1 2 3	Poor appetite	0 1 2 3
Bullies, threatens others	0 1 2 3	Difficultly playing quietly	0 1 2 3	Hears voices not there	0 1 2 3
Loses temper easily	0 1 2 3	Talks excessively	0 1 2 3	Sees things not there	0 1 2 3
Argues with adults	0 1 2 3	Is forgetful	0 1 2 3	Anxious/fearful	0 1 2 3
Defiant	0 1 2 3	Blurts out/interrupts others	0 1 2 3	Separation anxiety	0 1 2 3
Annoys others on purpose	0 1 2 3	Loses things	0 1 2 3	Physical complaints	0 1 2 3
Easily annoyed by others	0 1 2 3	Poor organization skills	0 1 2 3	Heart pounding/racing	0 1 2 3
Angry/irritable	0 1 2 3	Easily distracted	0 1 2 3	Sexual behavior problems	0 1 2 3
Destructive to property	0 1 2 3	Low energy/fatigue	0 1 2 3	Identity issues	0 1 2 3
Lies (to avoid trouble)	0 1 2 3	Unpredictable moods	0 1 2 3	Rigid/restrictive interests	0 1 2 3

Other symptoms: _____

Emotional health problems of family: (check all that apply)

	Mother	Father	Sister	Brother	Aunt	Uncle	1st Cousin	Grandparents
Alcohol/drugs	.							
Anxiety								
Attention Deficit								
Autism Spectrum								
Bipolar Disorder								
Depression								
Eating Disorder								
Learning Problems								
Post-traumatic stress								
Schizophrenia								
Suicide attempt								

RELATIONSHIPS WITH OTHERS

How does your child get along adults? Excellent _____ Good _____ Poor _____

How does your child get along with his/her siblings? Excellent _____ Good _____ Poor _____

How does your child get along with other children? Excellent _____ Good _____ Poor _____

Child History Form

Does your child attempt to make friends with other children? _____

Do other children attempt to make friends with your child? _____

Does your child play primarily with children his/her own age? _____Younger? _____ Older? _____

How would you describe your child's personality? _____

_____

Briefly describe your child's religious or spiritual beliefs, and place of worship (if any): _____

_____

What are your child's social interests, community/church involvements, extracurricular activities, sports, or clubs?

_____

_____

Does your child have any unusual habits or behaviors? _____

_____

How well does your child get along with others (i.e., peers, adults, siblings)? _____

_____

Has your child experienced any major life stressors / trauma / abuse?

_____

_____

Is there anything else that you think is important for me to know about you or your child?

_____

_____

_____

_____

Thank You,

Fresh Start for the Mind Staff

For Office Use Only:

DOI:	**Attendee(s):**
DOE:	