

Family and Child History Form

Child's Name _____ Date of Birth _____ Age _____

Siblings Names and Ages _____

Parent's Name _____

Married ___ Single ___ Divorced ___ Separated ___ Widow ___

Why is the child coming to therapy? _____

Describe how you understand your child's problem or behavior (when did it begin, how long has it lasted? How have you reacted? What have you tried?) _____

Describe any prior therapy your child or family has had, duration, and results. _____

Early History

Pregnancy: Any problems with the health of the mother or child? _____

Infancy: Colic, Eating, Illness, Hospitalizations, Sleep patterns, General Health _____

Developmental Milestones: Crawling, walking, speech, toilet training, temper tantrums, attachment to parents

Medical History

Allergies, Head injuries, Ear Infections, Eye Problems, Frequent Colds, Asthma, Traumas, Accidents, Surgery.

School History

How did your child do socially, emotionally, and academically?

Preschool _____

Kindergarten _____

Elementary Grades

Hobbies/ Special Interests/Pets _____

Describe a typical day in the child's life. How much TV, videos, and electronic games does the child watch each day? _____

Worrisome symptoms (phobias, nightmares, temper tantrums, withdrawal, bedwetting/soiling).

Describe your child's strengths _____

Family History

Please describe the child's relationship with brothers/ and or sisters. _____

Describe the child's relationship with mother. _____

Describe the child's relationship with father. _____

How are limits set and conflicts resolved in the family? _____

How openly are emotions expressed in the family? (fear, anger, sad, shame, happy, love, disgust, surprise) _____

Any major losses, deaths, separations, divorce, recent move, molestation, exposure to violence.

**PEGGY KRUGER
TIETZ PH.D.**
LICENSED PSYCHOLOGIST

Has any relative of parents had problems similar to the child's problem? _____

Anything else that impacts your child that you think I should know about.
