

MEDICAL HISTORY

6) List all medical hospitalizations:

Reason

Dates

7) Chronic Illnesses/Head Injuries:

8) List of medications for medical or mental health issues (present and past):

Medication

Dose

9) Previous Mental Health Treatment:

Yes _____

No _____

Out-patient Counseling:

Counselor/Psychiatrist

Date

In-patient Counseling:

Counselor/Psychiatrist

Facility

Date

In-school Counseling:

Counselor/Psychologist

School

Grade

Date

DEVELOPMENTAL HISTORY

10) Who does the child/teen live with? _____

Who has legal custody? _____

Prenatal Care: Yes _____ No _____ Full Term: Yes _____ No _____

If premature, how early? _____ Birth weight: lbs. _____ oz. _____

Type of delivery: spontaneous _____, cesarean _____, with instruments _____

Head first _____, breach _____

Was oxygen necessary for the infant? Yes _____ No _____

Was the infant discharged with the mother? Yes _____ No _____

Did the mother use alcohol/drugs/nicotine during pregnancy? Yes _____ No _____

If yes, please explain:

Difficulty sleeping as an infant _____, Colic _____, Breast fed _____, Regular formula _____

Developmental milestones (age): walked _____, spoke full sentences _____, toilet trained _____

EDUCATIONAL HISTORY

11) At what age did your child enter Day Care? _____

Did your child attend Pre-School? Yes _____ No _____

Please list all the schools your child has attended:

Please describe your child's last report card:

12) Goals of counseling: (What would you like to see happen as a result of counseling?)

13) Is there any other information that you believe would be helpful for the counselor to know?

I understand that this information is being provided to my child's Counselor only. It is my responsibility to share relevant information with my child's Pediatrician/Primary Care Physician.

Name of the person completing this questionnaire

Date