

## CHILD HISTORY

Date Completed \_\_\_\_\_

### Client Information:

Client's Name \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ Sex \_\_\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_

School Phone \_\_\_\_\_ 504, IEP, or other services: \_\_\_\_\_

Hand client uses for writing / drawing: Right \_\_\_\_\_ Left \_\_\_\_\_ Switches \_\_\_\_\_

Primary language \_\_\_\_\_ Secondary language \_\_\_\_\_

Client lives with: both parents \_\_\_ mother \_\_\_ father \_\_\_ other: \_\_\_\_\_

### Family Information:

Mother's Name \_\_\_\_\_

Address (Street, City, ST, Zip) \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-mail \_\_\_\_\_

Father's Name \_\_\_\_\_

Address (Street, City, ST, Zip) \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

E-mail \_\_\_\_\_

Names and ages of siblings \_\_\_\_\_

\_\_\_\_\_

Names and ages of others in household \_\_\_\_\_

**Medical Information:**

Primary Care Provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Current Medical diagnosis (1) \_\_\_\_\_

*if any* (2) \_\_\_\_\_

Current Medication(s) (names and dosages) \_\_\_\_\_

\_\_\_\_\_  
Previous/current therapies or testing \_\_\_\_\_

\_\_\_\_\_  
Who referred you to our practice? \_\_\_\_\_

Describe the problems, first major concerns and then minor ones: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_