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ABOUT MY CHILD

Please complete the following questionnaire as completely and honestly as you can about your child. Your answers will help me better understand your situation with your child. If you are completing this form anywhere other than my office, please remember that you are responsible for keeping the form confidential.

General Consent
I understand that by completing this form I am requesting services from Dr. Graham for my child, and that he will use the information in this form to determine what services he may be able to offer. If Dr. Graham determines that he is not able to provide services, he will give me appropriate referrals to other professionals.

If Dr. Graham determines that he is able to provide services, I give to him my general consent to use the information in this form. This consent does not allow for the release of any protected health care information to any other person or organization, except when mandated by law. I understand that this consent is governed by the practices described in the document titled *Notice of Privacy Practices for Protected Health Information*. I have received a copy of this document.

I hereby give permission to Dr. Graham to use my child's protected health information for purposes of treatment and payment.

_____ _____
Signature of parent/guardian Today's date

Name of person completing this form, and relationship to the child:
_____

Presenting Problem
Describe the problem(s) your child is having and when it (they) began: _____
_____
_____
_____
_____
_____
_____

Rate the severity of this concern, ***1*** being not at all severe, and ***10*** being very severe:_____

What seems to make the problem worse? _____
_____
_____

What seems to make the problem better? _____
_____
_____

What have you done to try to solve this problem? _____
_____
_____

Please check any symptoms your child is currently experiencing:

__ Aggression or angry outbursts
__ Alcohol abuse
__ Anxiety
__ Avoidance of people
__ Computer addiction
__ Depression
__ Difficulty concentrating
__ Difficulty thinking
__ Distractibility
__ Dizziness
__ Drug abuse
__ Eating disorders
__ Elevated mood
__ Fatigue
__ Fears (list)
_____
_____
_____
_____
__ Hallucinations
__ Headaches
__ Helplessness
__ Hopelessness
__ Impulsivity
__ Indecisiveness
__ Irritability
__ Loneliness
__ Memory problems
__ Mood swings
__ Muscle tension
__ Panic attacks
__ Racing thoughts
__ Restlessness or on edge
__ Sexual addiction
__ Sleeping problems
__ Stressed out
__ Suicidal thoughts
__ Trembling
__ Weight gain/loss
__ Withdrawal
__ Worrying
__ Worthlessness
__ Other Symptoms (list)
_____

List the child's previous mental health treatment (if any) and the provider(s): _____
_____
_____
_____
_____

List any mental health problems in the child's extended biological family: _____
_____
_____
_____

Pregnancy and Birth History
Was the pregnancy planned? _____ Was it full term? ___Yes ___No

How did the mother feel about this pregnancy? _____

How did the father feel about this pregnancy? _____

Was alcohol, drugs, or medications used during pregnancy? ___Yes ___No
If yes, please describe: _____
_____

Describe any problems with the pregnancy: _____
_____

Describe any problems with the birth: _____
_____

Developmental History
Was the baby ___breast fed ___bottle fed ___both?

Who has been the primary caregiver for the child? _____

Please estimate when the child first:

Crawled _____ Sat up on own _____

Fed self _____ Smiled _____

Ran _____ Stood _____

Said first words _____ Toilet trained _____

Said phrases _____ Walked _____

Were there any illnesses, behavioral difficulties, or discipline problems during early childhood?
_____
_____
_____
_____

If the child had temper tantrums, please describe when, how often, and about what? _____
_____
_____

How well has your child been able to make appropriate eye contact throughout his/her life?
_____

What discipline techniques were used, and how consistent was parental discipline? _____
_____
_____

Please describe both parents'/guardians' marital histories: _____
_____
_____

Medical History
Who is your child's primary care physician? _____

Date of last visit: _____ Date of last physical: _____

Are the child's immunizations up-to-date? ____Yes ____No

Check which of the following your child has experienced:

__ Arthritis
__ Asthma
__ Cancer
__ Chronic pain
__ Diabetes
__ Head injury/concussion
__ Headaches
__ Heart disease
__ Hepatitis
__ HIV
__ Hypertension
__ Hypoglycemia
__ High fevers
__ Kidney disease
__ Liver disease
__ Loss of consciousness
__ Lung disease
__ Meningitis
__ Migraines
__ Pregnancy
__ Seizures
__ Sexually transmitted disease
__ TB
__ Thyroid problems
__ Other (list)
_____
_____

For each item checked above, please describe your child's age at onset, and the treatment and outcome: _____
_____
_____
_____

List any hospitalizations or surgeries your child has had: _____
_____
_____

Please list all current medications, prescribed and over-the-counter, including herbal supplements. Include those prescribed for emotional or behavioral problems:

Medication	Dosage	Date started	Prescribed by	Condition prescribed for

Does your child have any allergies? _____
_____

Social History
Place of birth: _____

Where did your child grow up? _____

If your child is adopted, at what age? ___

If the child's family moved around, please describe: _____
_____

Please list all members of the household, their ages, and relationship to the child: _____
_____
_____
_____

Which family member(s) is the child close to? _____

List any trauma your child may have suffered (physical, sexual, emotional): _____
_____
_____
_____

Describe the child's relationship with the father: _____
_____

Describe the child's relationship with the Mother: _____
_____

Please describe any significant conflicts the child has with family members: _____
_____
_____

Whom does the child rely on for emotional support? _____
_____

What losses, changes, or transitions (including moves) have occurred in the child's life?
_____
_____
_____

What spiritual, cultural, or religious beliefs have influenced the child? If the child attends a church, temple, or synagogue (or other religious place of worship), which one? _____
_____

Relationship History
How does your child make friends? _____
_____

How does your child get along with others? _____
_____

Has your child ever bullied or been bullied? If yes, please explain. _____
_____
_____
_____

Educational History
What is your child's current year in school? _____

What kind of student is your child? _____

List any special educational services your child receives: _____
_____

How does your child get along with teachers and peers? _____
_____
_____

Does your child have any discipline problems in school? _____
_____

What are your child's strengths? _____
_____
_____

What are your child's weaknesses? _____
_____
_____

Legal History
Have you been court-ordered to bring your child in for therapy? ___Yes ___No

If your child experienced divorce, how has that impacted him/her? How has he/she adapted to any custody arrangement(s)? _____
_____
_____

List any current involvement you or your child has with the criminal or civil legal system:
_____
_____
_____

What additional information would be helpful for Dr. Graham to know? _____
_____
_____
_____
_____

Thank you so much for your time and thoughtfulness as you have completed this questionnaire.