Marsh Landing Behavioral Group
Psychological Assessment

Childhood History Form

Identifying Information

Child's Name: _____ DOB: _____ Age: _____

Nickname: _____ Sex at birth: ☐ Male ☐ Female

Father's Name: _____ Occupation: _____
Mother's Name: _____ Occupation: _____

Preferred Contact #: _____ ☐ Mother *or* ☐ Father

Phone Home: _____
Email: _____

Child presently lives with: _____

***** WHEN COMPLETING THIS FORM, PLEASE HIT THE TAB BUTTON TO PROCEED TO THE NEXT LINE FOR ADDITIONAL SPACE WHEN ANSWERING QUESTIONS AND CLICK ON THE BOXES****

Reason for Referral

Chief complaint (Purpose of current visit) *Examples: Anxiety, Depression*
_____

How long has this been a problem/concern?
_____
_____

What questions would you like answered from this evaluation?
_____
_____
_____

What concerns, if any, do you have regarding your child's development?
_____
_____
_____

Current Behavioral Concerns: *(Please check all that apply to your child)*

Attention and Behavior

- ☐ Failure to give close attention to detail, careless errors
- ☐ Difficulty sustaining attention
- ☐ Often does not listen when spoken to directly
- ☐ Does not follow thru on instruction, fails to finish schoolwork (due to opposition)
- ☐ Often has difficulty with organization
- ☐ Reluctant to engage in tasks that require sustained mental effort
- ☐ Often loses things
- ☐ Easily distracted
- ☐ Often forgetful
- ☐ Often fidgets
- ☐ Leaves seat when expected to remain seated
- ☐ Difficulty playing quietly
- ☐ Daydreams too much
- ☐ Less interested in friends
- ☐ Spends time alone
- ☐ Seems to be having less fun
- ☐ "On the go" as if "driven by a motor"
- ☐ Talks excessively
- ☐ School Grades Dropping

Mood

- ☐ Depressed mood most of the day for a two week period or longer
- ☐ Diminished interest in activities
- ☐ Significant weight loss
- ☐ Sleep problems
- ☐ Fatigued, slowed down
- ☐ Feelings of worthlessness
- ☐ Difficulty concentrating
- ☐ Suicidal ideation
- ☐ Auditory/ Visual hallucinations
- ☐ Inflated self-esteem
- ☐ Decreased need for sleep (feels rested after 3-4 hours of sleep)
- ☐ More talkative than usual
- ☐ Racing thoughts
- ☐ Distractible
- ☐ Increase in goal directed activity
- ☐ Irritable, mood swings
- ☐ History of temper outbursts. *If yes*, then how many episodes in past month? _____
- ☐ History of aggressive behavior. *If yes*, then how many episodes in last month? _____

Anxiety

☐ Excessive worry
☐ Difficulty controlling worry
☐ Phobias *(specify)* _____
_____
Does this limit the child's activities? *(describe)*_____
_____
☐ Heart palpitations
☐ Shortness of breath
☐ Anxiety in school situations
☐ Recurrent intrusive thoughts
☐ Repetitive behaviors (hand washing, checking things)

Medical History

Age of mother at child's birth _____
PREGNANCY- Complication(s): ☐ YES ☐ NO
If yes, please explain: _____
_____
Mother's alcoholic consumption during pregnancy: ☐ YES ☐ NO
Describe if beyond occasional drink: _____
Medications taken during pregnancy: _____
_____

DELIVERY: Birth weight: _____ Full Term or Pre-Term? _____
Complication: *(Please describe)* _____

If your child's medical history includes any of the following, please note the age when the incident occurred and any other pertinent information.

Please circle those that apply:
Vision: ☐ Normal ☐ Glasses ☐ Contacts ☐ Never tested
Hearing: ☐ Normal ☐ Hearing Aid ☐ Never tested

Prescription allergies: ☐ YES ☐ NO
Please list: _____
Adverse reactions: _____

Serious childhood illnesses/diseases: ☐ YES ☐ NO
Please explain: _____
_____

Serious bodily injury: ☐ YES ☐ NO
Please explain: _____
_____

Serious Head Injury: ☐ YES ☐ NO
Please explain: _____
_____

Car accident: ☐ YES ☐ NO
Please explain: _____
_____

History of:
☐ Seizures
☐ Loss of Consciousness
☐ Convulsions
☐ Coma
☐ Persistent high fevers
If yes, please describe: _____
_____

Hospitalizations: _____
_____

Chronic health conditions: _____
_____

Current primary physician and contact information: _____
_____

Current Medication(s) **(CURRENT ONLY)** ***Include any Vitamins or Supplements***

Name of Medication	Dosage	Purpose of medication	Who Prescribed the Medication

Psychiatric History

Current or Recent Mental Health Care Providers *(Psychiatrist/Counselors)*

Provider	Address	Purpose of Treatment	Dates of Treatment	Medication Management or Therapy?

Previous Mental Health Evaluations and Treatment *(Hospital, Psychological, Testing)*

Name of Doctor, Agency or Hospital	Location (City or State) and Date of Service	Reason for Evaluation and Findings

Previous Psychiatric Medication History

Name of Medication	Dosage	Dates of Treatment	Purpose of medication	Benefits and Side Effects

Developmental History *(Please circle those that apply)*

Developmental Milestones

Speech and Language: ☐ Early ☐ Normal ☐ Late

Motor: ☐ Early ☐ Normal ☐ Late

Self-help Skills: ☐ Early ☐ Normal ☐ Late

Temperament in infancy: ☐ Easy ☐ Average ☐ Difficult

Current Appetite: ☐ Poor ☐ Average ☐ Excessive

☐ Healthy ☐ Unhealthy

Current Sleep: ☐ Limited ☐ Good ☐ Excessive
☐ Middle of night awakenings ☐ Talking/ walking in sleep

Motor Coordination: Fine Motor: ☐ Poor ☐ Average ☐ Good
Gross Motor: ☐ Poor ☐ Average ☐ Good

Current School Adjustment: ☐ Poor ☐ Average ☐ Good

School History

Current School: _____ Current Grade: _____

Special Education placement: ☐ Yes ☐ No
If yes explain type of qualification (Other Health Impaired, Reading Disability, etc.):
_____

Please check educational supports that your child receives:
☐ Resource Teacher
☐ Self-Contained Classroom
☐ Speech Therapy
☐ Physical Therapy
☐ Occupational Therapy
☐ Counseling
☐ 1:1 Paraprofessional Support

Any school difficulties/failures or grade retention: ☐ Yes ☐ No
If yes please explain: _____
_____
_____

Has the school reported behavior problems in class: ☐ Yes ☐ No
If yes please explain: _____
_____

Hobbies/Interests outside of school: _____
_____

How does your child get along with other children?
Please describe: _____
_____

Grade Performance
1st-5th ☐ A ☐ B ☐ C ☐ D ☐ F's ☐ Inconsistent School_____

6th-8th ☐ A ☐ B ☐ C ☐ D ☐ F's ☐ Inconsistent School_____

9th-12th ☐ A ☐ B ☐ C ☐ D ☐ F's ☐ Inconsistent School_____

Subject area(s) that present most challenge for your child: _____
_____

Family History

Please list the current members of your household

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parents: ☐ Married ☐ Separated ☐ Divorced
Length of time: _____

Sibling Conflict: ☐ Mild/Typical or ☐ Severe/Aggressive

Any significant losses or changes in the past year: _____
_____

Where else has the child lived? *(State/Country)*_____
_____

Please check all that applies and include which family member: (parents, grandparents, siblings, aunts, uncles, and cousins)

☐ Attention Difficulties_____
☐ Learning Difficulties _____
☐ Developmental Disabilities_____
☐ Genetic Disorder _____
☐ Tics _____
☐ Anxiety_____
☐ Depression _____
☐ Obsessive Compulsive Disorder (OCD) _____
☐ Schizophrenia _____
☐ Bipolar Disorder (Manic Depressive)_____
☐ Violence _____
☐ Substance Use _____
☐ Suicide Attempt(s) _____

Additional Comments: _____
_____
_____

We are happy to provide a copy of the evaluation of your child to any physician(s), school administrator, or teacher on your behalf. In order to do so, a signed Release of Information form is required for each individual. If the information is to be released to a school, please name the specific individual to whom we will be sending a copy of the evaluation. It will be important for you to keep an additional copy on file, as the Release of Information you will be signing is good for 90 days only. After that time period, it will be necessary for you to come in and sign a new Release of Information if you require additional copies. We require that a minor child be accompanied by a legal guardian to all appointments.

Completed by: _____ Date: _____
Print Name:

Sign: _____ Relationship to Patient: _____