

CHILD DATA SHEET

DATE _____

NAME _____
(Last) (First)

FATHER _____
(Name) (Date of Birth) (Highest Grade Completed)

(Mar/Div/Dec.) (Occupation) (Work Hours)

MOTHER _____
(Name & Maiden Name) (DOB) (Highest Grade Completed)

(Mar/Div/Dec.) (Occupation) (Work Hours)

RELATIONSHIP OF CHILD TO PARENT
(Bio/Adop/Step/etc.) _____
(Mother) (Father)

SIBLINGS
Name Birthdate School&Grade/Employer Address

OTHERS IN HOUSEHOLD

CHILD'S DEVELOPMENTAL HISTORY

MOTHER'S PREGNANCY: _____ Normal _____ Difficult (explain)

Medications used during pregnancy (explain) _____

Ingestion or inhaling during pregnancy: _____

_____ smoking _____ # cigarettes per day
_____ alcohol _____ amt if more than occasional
_____ meds (please list)

_____ illness during pregnancy _____

BIRTH Type of delivery _____
 Known complications _____
 Weight _____ Prematurity _____ How much premature _____

INFANCY Approximate age of walking _____ talking _____
 Approximate age of weaning _____
 Feeding problems _____

 Approximate age of toilet training _____ Problems (explain) _____

 Characteristic habits (thumbsucking, security blanket, etc) _____

 Sleeping problems _____

CHILDHOOD: Are there any fears or troublesome habits now, or in the past? (explain) _____

 Any problems about separating from parents, now or in the past? (explain) _____

MEDICAL HISTORY:

Problems (check all that apply)

- Anxiety
- Confused thinking
- Drinking
- Drugs/Alcohol
- Eating
- Mood (depressed or excited)
- Physical health
- Poor Memory
- Relationships
- School
- Sexual
- Work

Others (please specify) _____

Past or Present Illnesses _____

Please described meds you are currently using
 Meds Dose Frequency M.D.

Please list any allergies

FAMILY HISTORY:

	NO	YES
Learning problems	_____	_____
Speech or Language Problem	_____	_____
Severe emotional problem require hospital	_____	_____
Epilepsy (seizures)	_____	_____
Hyperactivity	_____	_____
Drug or Alcohol Problem	_____	_____

If yes, please describe _____

