CHILD New Client HISTORY

Linda Piantieri, MA, NCC, LMFT, LMHC
1850 Lee Road, Suite 212, Winter Park, FL 32789
407-719-2525 www.lindapiantieri.com

Today's Date: ________________

Name of Child: ____

Age: __________ Date of Birth: ______________________ Gender ______________________

Name of Adult Completing History: ________________________________

Relationship to Child: ____

Any legal/social agency involved with child: ______________________________

1. **Chief Complaint** — Please explain your present concerns about your child and what you think is causing the problem:

____
____
____
____
____

2. **Onset** — When did you first notice the concern/problem? What else was happening at that time that might be important?

____
____
____
____
____

3. **Course** — How were you and the child referred here (school, court, etc.)? What have you already tried in order to solve the problem?

____
____
____
____
____
____
____
____
____

4. **Family Composition**
   - Biological parents ____________________
   - Dates married/separated/divorced ____________________
   - Parental relationship: Strained / Fair / Strong ____________________
   - Custody / Visitation ____________________
   - Parent / Guardian Occupations ____________________
   - Siblings: DOB / Schools ____________________

5. **Significant Others** — Are there other individuals who play a large role in your child's life?
   l____________________
   ____
   ____
   ____
   ____

6. Are there any immediate family members that reside outside of the child's home? Yes / No

   If yes, who and where do they live ____________________

   How many homes has your child lived in? ________ How many caretakers has your child had? ________

7. Describe what kind of person the child is — his/her personality, attitudes, values, etc. To whom is he/she most similar, and in what way(s)?
   ____
   ____
   ____
   ____
   ____

Child Medical and Psychiatric History

8. Pregnancy

   Illnesses/Complications: ____________________

   Medications, tobacco, alcohol, other drugs during pregnancy: ____________________

   ____

   Length of gestation: ____________ Delivery type (e.g., caesarian, breach): ___________

   Birth weight: ____________________ Apgar rating (if known): ______________

   Problems during delivery or shortly thereafter: ____________________

   Length of stay in hospital: ____________________

9. Developmental milestones (in months):

   Sat alone ___________ Walked ___________ Talked in sentences ___________

   Weaned ___________ Fed self ___________ Tied own shoes ___________

   Toilet training (ease or difficulty) ____

10. Injuries/Illnesses/Hospitalizations:

    Date Location Reason Outcome

    ____

    ____

    ____

    ____

11. Please list your child's current physician, including address, phone number, and date of most recent exam: ____

    ____

12. Does your child have any current medical problems, including allergies? _______________

    ____

13. What medications is your child currently taking and for what condition? By whom were the medications prescribed? ____

    ____

14. Has your child had any previous psychiatric/psychological evaluations/treatments, including counseling? Yes / No If yes,

    Dates Treating Professional Reason Outcome

    ____

    ____

    ____

    ____

15. What temperamental qualities does your child demonstrate?

	Less than average	Average	More than average
Activity level	_______	_______	_______
Affection	_______	_______	_______
Persistence	_______	_______	_______
Moodiness	_______	_______	_______
Intensity of emotional response	_______	_______	_______

16. **Family Medical and Psychiatric History**

	Maternal Relatives	Paternal Relatives
Alcoholism	______________________	______________________
Drug abuse	______________________	______________________
Mental illness (specify)	______________________	______________________
Psychiatric hospitalizations	______________________	______________________
Mental retardation	______________________	______________________
Learning disabilities	______________________	______________________
Hyperactivity	______________________	______________________
Suicide or attempts	______________________	______________________
Other medical illnesses (specify)	______________________	______________________

17. Has your child or any member of your family been a victim or perpetrator of physical, sexual, emotional, or substance abuse or neglect? Yes / No If yes, please explain

____

____

18. Has your child witnessed any violence or abuse? Yes / No If yes, please explain

____

____

19. What are your child's hobbies and interests? (Boy/Girl Scouts, sports, reading, etc.) How much time per week does your child spend in each?

____

____

20. Does your child have diagnosed learning delays? Yes / No If yes, what type?

____

21. Is your child in special classes at school? Yes / No If yes, what type? _______________

22. Has your child been diagnosed with behavior problems? (e.g., ADHD) Yes / No
If yes, what type? ____

23. How many hours a day does your child typically watch TV? __________What are your child's favorite shows? ____

24. When does your child typically do his/her homework? (e.g., after school, before dinner, after dinner) ____

25. How many hours per day does your child spend with:

Parents?	Weekday ____	Usual activities ________________________________
	Weekend ____	Usual activities ________________________________
Siblings?	Weekday ____	Usual activities ________________________________
	Weekend ____	Usual activities ________________________________
Friends?	Weekday ____	Usual activities ________________________________
	Weekend ____	Usual activities ________________________________
Other caretakers?	Weekday ____	Usual activities ________________________________
	Weekend ____	Usual activities ________________________________
Alone?	Weekday ____	Usual activities ________________________________
	Weekend ____	Usual activities ________________________________

26. What is your child's bedtime? Weeknights _____________ Weekends ____________

    Is this enforced? Always ___ Most of the time ___ Sometimes ___ Never ___

    What is your child's routine one hour before bedtime? ________________________________

27. Does your child share a bed or bedroom with a sibling or parent? Yes / No If yes, please explain ____

28. Does your child shower or bathe with a sibling or parent? Yes / No If yes, please explain ____

29. Please describe your child's interactions with the following:

    Parents ____

    Siblings ____

    Peers ____

    Teachers ____

30. **Discipline** — How many times in the past week have you had to:

    ____ Put your child in "time out" (or send to his/her room) For how long? ____________

    ____ Take away privileges or ground your child For how long? __________________

    ____ Explain why something was wrong

    ____ Shout, yell, or scream at your child

    ____ Threaten to spank or hit your child but not actually do it

    ____ Spank your child on the bottom with your bare hand

    ____ Hit your child on the bottom with something like a belt, hairbrush, or stick

    ____ Slap your child on the hand, arm, or leg

    ____ Slap your child on the face, head, or ears

31. Have you noted any problems in these areas? If yes, please explain.

Depression? Yes / No ______________________________

Anger? Yes / No ______________________________

Grief? Yes / No ______________________________

Anxiety? Yes / No ______________________________

Regressed behaviors (acting like a younger-aged child)?

Yes / No ______________________________

Social skills? Yes / No ______________________________

Detachment? Yes / No ______________________________

32. Please share any additional information about your child you feel may be relevant (frequent moves, death of family member/pet, etc.) ______________________________

____

____

____

33. Does your child display any of the following behaviors?

	Presently	Prior	How long	How often	At home	At school
Hits adults						
Hits siblings						
Hits peers						
Sets fires						
Destroys property						
Uses weapons						
Drinks alcohol						
Smokes						
Uses drugs						
Steals						
Lies						
School truancy						
Poor grades						
Problems with friends						
Withdrawn						

	Presently	Prior	How long	How often	At home	At school
Sexual acting out						
Talks back						
Breaks rules						
Wets bed						
Daytime wetting						
Soiling problems						
Hurts animals						
Nightmares						
Night terrors						
Sleeps too much						
Sleeps too little						
Fearful						
Overactive						
Runs away						
Low energy						
Poor concentration						
Difficulty making decisions						
Blames others for own mistakes						
Deliberately annoys others						
Suicidal gestures or statements						
Change in eating habits						
Needs constant supervision						