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Remember the Joy
Supporting Kids
Coaching Parents
Increasing Joy!

Child History

Child's Name: _____ DOB: _____

Nickname _____ Today's Date: _____

Person interviewed: _____

Family History: Counseling Involvement with law

Anyone in family use: Drugs _____ Tobacco _____ Alcohol _____

Any difficulties during pregnancy/delivery?

Family history of Mental health concerns Medical concerns

Abuse (physical, sexual, verbal)

Serious loss (death in family, frequent moves, divorce, physical separation from parent)

Describe:

Current Stresses:

Child history:

Has child experienced any of the following medical problems?

<input type="checkbox"/>	A serious accident	<input type="checkbox"/>	Hospitalization	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	Head injury	<input type="checkbox"/>	High Fever	<input type="checkbox"/>	Convulsions/Seizures
<input type="checkbox"/>	Eye/ear problems	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Hearing problems
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Other				

Current medical problems or physical handicaps:

Any medications:

Child history of Mental health concerns Medical concerns
 Abuse (physical, sexual, verbal)
 Serious loss (death in family, frequent moves, divorce, physical separation from parent)

Has child made statements of wanting to hurt him/herself or someone else?

Purposely hurts self or someone else?

Describe:

Education:

School	Address
Phone:	Fax
Current Grade	Teacher

What does teacher say about child?

Other education or group settings (pre-school, childcare):

Receiving special services?

Difficulties seen in other settings that are not seen at home?