**RUSSELL B. HANFORD, Ph.D.**

Licensed Clinical Psychologist

400 E. Pine Street
Suite 220
Seattle, WA 98122
206.409.9613

# CHILD AND FAMILY HISTORY FORM

Parents: Thank you for taking the time to complete this form. By so doing, you are providing me with important background information that will allow us to make the most efficient use of our early sessions.

Child's Full Name:_____ Date completed:_____
Completed by:_____
Child's birth date: _____ Age: _____

**Contact Information:**
Parent /Guardian_____ Phone: (h) _____
Address:_____ (w)_____
_____ (cell)_____

Parent /Guardian_____ Phone: (h) _____
Address:_____ (w)_____
_____ (cell)_____

School/District_____ Phone:_____
Address:_____ Grade:_____
Teacher (who knows child/adolescent best):_____

Previous Therapist(s)_____ Phone:_____
_____ _____
Primary Care Physician_____ _____

**Primary Concerns:**

_____
_____
_____
_____

**Goals of Therapy:**

_____
_____
_____

**Birth and Developmental History:**
Information requested pertains to the *bio*logical mother of the child.

1. Did the mother take any medications during pregnancy?

| Name of medication | Reason taken | Trimester |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

2. Did the mother smoke cigarettes, drink alcohol, or use drugs during pregnancy?

| Substance | Amount used per week | Trimester |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

3. Did the mother experience any medical problems during pregnancy? Please describe.

_____

_____

4. Length of pregnancy: ___ weeks Age of mother at time of child's birth:___

5. Were there any problems during the delivery or shortly thereafter? If yes, please describe.

_____

_____

Delivery was: Vaginal___ C-section___

6. Did your child have any medical problems during infancy?_____

_____

feeding difficulties?_____

"colic"?_____

sleep difficulties?_____

7. How would you describe your child's temperament as an infant? Was he/she an "easy" baby? Was he/she cuddly and did he/she like to be held?

_____

_____

8. At what age did your child complete the following developmental milestones?

| Milestone | Age |
|---|---|
| Walk | _____ |
| First words (other then "mama" and "dada") | _____ |
| 2-3 word sentences | _____ |
| Toilet trained for bladder-day | _____ |
| Toilet trained for bladder-night | _____ |
| Toilet trained for bowel | _____ |

**Medical History**

9. Does your child have any chronic health problems (e.g. asthma, diabetes, heart disease)?

_____

_____

10. Has your child had any surgeries, hospitalizations, or inpatient psychiatric stays?

| Year | Procedure/Reason for Hospitalization | Outcome |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

11. Is your child taking any type of medication currently?

| Name of medication | Dosage | Reason | Date begun |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Name of physician managing medications _____
This physician is a ___ primary care MD ___ psychiatrist ___ other (_____)

12. Has your child ever taken any psychiatric medications in the past?

| Name of medication | Dosage | Reason | Dates |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**School**

13. Does your child have any of the following school concerns?
Attendance ___ Behavior ___ Academic ___ Other _____
_____

14. Is your child enrolled in any special education/advanced classes? If yes, please describe.
_____
_____

15. How would you describe your child's peer relationships?
_____
_____

**Abuse/Self-Harm History**

16. Has your child experienced any of the following types of abuse?
Physical ___ Sexual___ Emotional ___ Neglect ___

17. Does your child have any history of suicidal or self-harm behaviors? If yes, please describe.
_____
_____

**Family History**

Parent (first name:_____)
Educational level _____
Occupation _____

Parent (first name:_____)
Educational level _____
Occupation _____

Client's Siblings:
Name _____
Age _____
Name _____
Age _____

Name _____
Age _____
Name _____
Age _____

18. What is your child's current living situation?

_____

_____

_____

Do any of your child's *bio*logical relatives have the following conditions? Please check all that apply, past or present.

| | MOTHER | FATHER | MOTHER'S FAMILY | FATHER'S FAMILY | CHILD'S SIBLINGS |
|---|---|---|---|---|---|
| Intellectual Disability | | | | | |
| Autism | | | | | |
| Learning problems | | | | | |
| Attention problems | | | | | |
| Hyperactivity | | | | | |
| Epilepsy | | | | | |
| Alcoholism | | | | | |
| Drug Abuse | | | | | |
| Depression | | | | | |
| Suicide | | | | | |
| Anxiety Disorder | | | | | |
| Bipolar Disorder | | | | | |
| Schizophrenia | | | | | |
| Psychosis | | | | | |
| Criminal history | | | | | |

Thank you again for taking the time to complete this form. The information you have provided is much appreciated.