the Samaritan Center
Healing - Hope - Growth

CONFIDENTIAL

Childhood History Questionnaire

Child's name:_____ Birthdate: _____

Grade level in school: _____ Name of school:_____

Mother's name: _____ Birthdate: _____

Address: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Occupation: _____Highest level of education: _____

Medical problems: _____

Alcohol/drug use: _____

Father's name: _____ Birthdate: _____

Address: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Occupation: _____Highest level of education: _____

Medical problems: _____

Alcohol/drug use: _____

Relationship status of parents (please include marriages separations divorce, death, etc. of each) :

_____

With whom does the child currently live:

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

If parents do not live together, what is the visitation arrangement:_____

_____

If the child has/had other caretakers (relatives, babysitter, daycare, etc.), who have they been and at what ages?

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

Developmental history

Were there complications during the pregnancy or birth of this child? _____Yes _____No

If yes, please describe_____

_____

Is child adopted? _____Yes _____No

If so, does the child know he/she is adopted? _____Yes _____No

At approximately what age did the child: crawl _____, walk _____,

put words together to express needs _____, bladder control _____,

bowel control _____, stay dry at night _____,

start sleeping through the night _____

What was the child's early temperament _____

Current Behavior

Please describe compliance vs. non-compliance, lying/stealing, fears, habits etc.: _____

_____

_____

_____

How are behaviors different at home versus school or other places?:_____

_____

_____

Relationships

Please describe the relationship between the child and mother: _____

_____

_____

Please describe the relationship between the child and father: _____

_____

_____

Please describe the relationship between the child and siblings: _____

_____

_____

What are the child's sleep behaviors (Does the child wake up on their own, difficult to wake up, sleep with parent, sleep with light on, fight going to bed, etc.): _____

_____

Time child typically goes to bed: _____ Time child gets up: _____

Please describe the child's eating patterns: _____

_____

Is there a history for: (check all that apply)

___Nail Biting	___Stuttering	___Sleepwalking	___Daydreaming	___Learning Problems
___Shyness	___Night Terrors	___Overweight	___Thumb sucking	___Imaginary Playmates
___Tics	___Slow Talking	___Bowel Problems	___Crying Spells	___Fear of Playmates
___Soiling	___Bedwetting	___Repeated Vomiting	___Temper Tantrums	___Repeated Nightmares
___Slow Physical Development		___Excessive Fighting	___Other_____	

School History

Current grade: _____ Number of schools attended: _____

How is the child doing academically? _____

Has the child been, or currently enrolled, in special classes? _____Yes _____No

If yes, what subjects:_____

Motivation: _____

Does the child have friends? _____

Medical History

Height _____ Weight _____

Past medical problems/injuries/medications _____

_____

Current medical problems/medications: _____

_____

Current doctors: _____

_____

History of: (check all that apply)

___ Seizures ___ Head trauma ___ Allergies ___ Headaches

___ Overweight ___ Underweight ___ Chronic pain ___ Other:_____

Family history of hereditary illness or mental illness: _____

_____

Overall strengths (as viewed by parents): _____

_____

Overall strengths (as viewed by the child): _____

_____

Why are you seeking counseling at this time?_____

_____

_____

_____

_____