

Connecticut Psychiatric Partners, P.C.

CHILD'S HISTORY QUESTIONNAIRE

Today's Date: _____

Child's Full Name: _____ Date of Birth: _____

Name of person completing this form & relationship: _____

CONTACT INFORMATION

Parent #1 full name & address: _____

Occupation: _____

Phone #: _____

Parents #2 full name & address: _____

Occupation: _____

Phone #: _____

Other primary caregiver (Guardian/Significant Other/Other)

Caregiver's full name & address: _____

Phone #: _____

Emergency Contact (other than primary caregiver):

Name & Address: _____

Phone # _____

What are the main concerns you have about your child?

Child's Race and Religion: _____

Is the child adopted? Yes _____ No _____

Other children in the family:

Name	Gender	Date of Birth	Age	Relation to child
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other persons living in the home (significant other, friend, grandparents, foster child, etc) _____

Languages spoken in the home: _____

Agencies or professionals currently providing services to your child and family.

Agencies or professional _____ Age of child when services began _____

PREGNANCY HISTORY

During pregnancy with this child did the mother experience any of the following:

Medical problems No _____ Yes _____ If yes, how long _____

Special diet No _____ Yes _____ If yes, how long _____

Medications No _____ Yes _____ If yes, How long _____

Length of pregnancy Full-term(38-42 weeks) No _____ Yes _____

Number of weeks at birth _____

Any accidents/injuries No _____ Yes _____ If yes, describe _____

BIRTH HISTORY

Age of Mother at birth of child _____

Complications for mother during delivery No _____ Yes _____

If yes, list _____

Child's birth weight _____

Did the child need:

Oxygen No _____ Yes _____ If yes, why? _____

Special care No _____ Yes _____ If yes, why? _____

How long did the child stay in the hospital after birth? _____

How long did the mother stay in the hospital after birth? _____

Describe your child in the first 6 months

Easy baby No _____ Yes _____

Enjoys people No _____ Yes _____

Irritable No _____ Yes _____

Difficult to sooth No _____ Yes _____

Sleep/wake cycle poorly regulated No _____ Yes _____

Unusually quiet No _____ Yes _____

Unusually sick No _____ Yes _____

Feeding difficulties No _____ Yes _____

Strong reaction to light/sound/touch No _____ Yes _____

Colic No _____ Yes _____

FAMILY HISTORY

Please list any medical or psychiatric illness that runs in your family: _____

Child's Early Development (specify age)

- Sat without support _____
- Crawled _____
- Walked without support _____
- Used single words _____
(other than mama or papa)
- Used 2-3 word sentences _____
- First began to sleep through night _____
- Daytime wetting stopped _____
- Bed-wetting stopped _____
- Bowel control _____

CHILD'S MEDICAL HISTORY

Health Care Providers:

Primary care physician/pediatrician name & address:

Phone: _____

Date of last complete physical examination: _____

Does your child have any allergies (environmental, food/medication)? No _____ Yes _____

If yes, please list _____

Does your child take any medications? No _____ Yes _____

(Include vitamins, over-the-counter drugs, and herbal medications) Name

	Dosage	Frequency	Date Began
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any history of self harm/suicide attempts:

Firearms in the house /access to firearms:

Has your child ever been hospitalized for any reason: No_____ Yes_____

If yes, describe:

Reason	Date	Place	Length of stay

Does your child have a current or past history of:

	No	Current	Past	List
Head injury				
Broken bones				
Surgeries				
Birth defects				
Poisoning (e.g.: lead)				
Heart problems				
Kidney problems				
Liver disease				
Lung disease				
Blood disease				
Cancer				
Seizure				
Other neurological problems (e.g.:headaches)				
Genetic disorder				
Hormonal problems (e.g. diabetes, thyroid)				
Skin problems				
Lyme disease				
Impaired Sight				
Impaired Hearing				
Speech Difficulty				
Sleeping Difficulty				
Eating Disorder				
Sleep Apnea				
Severe vomiting				
Choking events				
Other problems				

Is your family facing any significant stressors just now? _____

Is there anything else you would like us to know that would assist us in understanding your child? _____
