Dorit Atar, LLC www.counselingwithdorit.com Tel: 770-609-5343

Child History Form

Child's Name: _____Birth Date: _____
Today's Date: _____

Gender: male female

Legal status of child: Birth Adopted (age when adopted: _____) Donor Sperm Donor Egg
Stepchild Foster

If parents are divorced: Joint legal/physical custody Sole physical custody Sole legal custody

Present concerns/reasons you are seeking services? _____
_____
_____
What symptoms is the child experiencing?_____
_____
_____

When did this start to be a concern? _____

Brothers/Sisters: Name Age Gender
_____
_____
_____
_____
_____

Other individuals living in the child's home and their relationship to child:
_____
_____
_____

Infancy and Early Childhood Development:
Child's Physician: _____Clinic and address: _____
_____
Were there any complications during pregnancy with your child? _____
_____
Were any medications or alcohol/drug use during pregnancy?_____
_____
Were there any complications during or shortly after birth? _____
_____
Does your child have any current medical conditions?_____
_____

Is your child currently on medication? Yes No (if yes, please indicate below type and dosage)

Name of medication Dosage Date first prescribed Physician

_____

_____

Has your child received previous mental health services? No Yes (If yes, please describe below)
Type of services and concern Provider/Facility Dates of service

_____

_____

_____

Has your child experienced any of the following?
Physical abuse _____
Sexual abuse _____
Verbal/emotional abuse _____
Exposure to domestic violence abuse _____
Are there any legal issues that involve your child? _____

Family history of mental health problems (for example, depression, learning difficulties, ADHD, anxiety, alcoholism, mental retardation, schizophrenia, bipolar disorder, etc.): _____

_____

_____

_____

Child's Current School: _____ Current Grade: _____
Is your child receiving special education services: Yes No If yes: _____
Does your child have any behavioral problems at school? _____
Experiencing social difficulty? _____

_____

What is your child's current use of caffeine? _____
What time does your child go to bed? _____
How long does it usually take for the child to fall asleep? _____
Does your child wake during the night? _____
At what time does your child wake in the morning? _____
How many hours of sleep does your child typically get at night? _____
How many days per week does your child engage in at least 30 minutes of exercise? _____