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CHILD INFORMATION FORM

Date: _____Patient Name: _____DOB:_____

CURRENT PROBLEMS

Please describe your child's current difficulties and reason for seeking services_____

_____

_____

PLEASE CIRCLE ANY CURRENT DIFFICULTIES:

Sadness	Irritability	Anger	Anxiety	Panic Attacks
Obsessive Thinking	Compulsive Behavior	Short Attention Span	Social Withdrawal	Relationship Problems
Fatigue	Worry	Mood Swings	Guilt	Hopelessness
Difficulty Learning	Explosive Behavior	Impulsive Behavior	Verbal Aggression	Physical Aggression
Nightmares	Flashbacks	Hyperactivity	Weight Loss	Weight Gain
Frequent Crying	Suicidal Thinking	School Problems	Separation Anxiety	Oppositional Behavior
Self-injury	Suspiciousness	Fire Setting	Insomnia	Fears
Somatic Complaints	Sexual Acting Out	Easily Embarrassed	Avoidant Behaviors	Cruelty to Animals
Manipulates	Tics	Underactive	Uncoordinated	Talks Back
Delayed Onset Sleep	Excessive Sleeping	Lack of Motivation	Repetitive Behaviors	Sexual Preoccupation
Immature	Truancy	Cries Easily	Lying	Messy
Perfectionistic	Bedwetting	Soiling Self	Interest in Fire	Difficulty Attaching
No Desire for Social Relationships	Temper Tantrums	Developmental Delays	Easily Distracted	

TURN PAGE OVER

PLEASE CIRCLE ANY RECENT OR CHRONIC STRESSORS:

Birth of Sibling	Foster Care	Recent Move	Family Conflict	Inadequate Housing
Health Problems	Change of School	Financial Change	Conflict with Teachers	Conflict with Peers
Health Problems in Family	Death of Family Member or Friend	Out of Home Placement	Court Proceeding	Remarriage of Parent
Inadequate Financial Resources	Academic Difficulties	Loss of Relationship	Conflict with Siblings	Hospitalization

MENTAL HEALTH TREATMENT HISTORY

Current and/or Past Providers_____

_____

Past and Current Diagnoses _____

Inpatient Treatment __Yes __No If yes, when and where_____

Was past treatment helpful __Yes __ No Why _____

_____

Current Psychotropic Medications _____

Past Psychotropic Medications _____

Past Suicide Attempts __Yes __No History of Suicidal Ideations __Yes __No

DEVELOPMENTAL/MEDICAL HISTORY

Pregnancy and Birth

Duration of Pregnancy_____

Smoking during pregnancy __Yes __No # Daily_____

Alcohol during pregnancy __Yes __No Amount _____

Drugs during Pregnancy __ Yes __ No Type _____

Medications during pregnancy __Yes __No Name of Medications_____

Pregnancy Complications _____

Delivery __ Spontaneous __ Induced Duration of Labor _____

__ Normal __ Cesarean __Breech Birth Weight _____

Birth Complications ___ Yes ___ No Describe _____

Developmental Milestones

Age of- Walking _____ Saying Words _____ Toilet Training _____

Medical Information

Primary Care Physician_____ Specialist/s _____

Current Medications _____

_____

Height _____Weight_____ Weight Change __Yes __No Describe_____

Sleep Impairment __Yes __No Describe_____

Current and Past Illnesses/Disorders (include dates and/or ages) _____

_____

Surgeries ___ Yes ___ No Describe _____

Head Injuries ___ Yes ___ No Describe _____

__ without loss of consciousness __ with loss of consciousness

Seizures __ Yes __No Allergies ___ Yes ___ No Describe _____

Frequent Strep Infections __Yes __No If yes, when was the last infection_____

History of Abuse

__Physical Abuse ___Yes ___No If yes, by whom_____

__Sexual Abuse ___Yes ___No If yes, by whom _____

__Emotional/Verbal Abuse ___Yes ___No If yes, by whom _____

__Abandonment/Neglect __ Yes __ No Describe _____

Witness of Abuse Physical ___ Yes ___No Sexual ___Yes ___ No

Removed from home ___ Yes __ No Perpetrator of Abuse __Yes __No

Other Developmental and Medical Information

_____

_____

_____

TURN PAGE OVER

FAMILY INFORMATION

Mother_____ Educational Level_____

Occupation_____ Employer_____

Father_____ Educational Level _____

Occupation_____ Employer_____

Parents are __ Married __ Separated __ Never Married __ Divorced/Year_____

__ Mother Remarried __ Father Remarried

Siblings (Name/Age) _____

Half/Step Siblings (Name/Age) _____

What is the custody arrangement, per court order, of the child _____

_____

Did you bring a copy of the custody papers __Yes __No

Describe family relationships (past and current) _____

_____

_____

Family History of

Substance Abuse __Yes __No If yes, describe _____

Mental Illness __Yes __No If yes, describe _____

Suicide __Yes __No If yes, describe _____

Violence __Yes __No If yes, describe _____

Other Family Information

_____

_____

SOCIAL HISTORY

Describe peer relationships _____

Relationship with Authority __ Oppositional __ Overly Compliant __ Neutral

Current Social Support __ Friends __ Family __ Other _____

Hobbies/Interests _____

Difficulty getting along with others __ Yes __ No If yes, please describe_____

_____

TURN PAGE OVER

EDUCATIONAL HISTORY

School_____ Current Grade _____ Teacher _____

Attended __Day Care __Pre-School

Special Education Services __Yes __No If yes, services are based on what disability

_____

Behavioral problems at school __ Yes __ No If yes, describe _____

_____

Repeated grades __ Yes __ No If yes, which grade _____

Reason for Retention _____

Suspensions/Expulsions __ Yes __ No If yes, describe _____

Performance/Achievements _____

Attitude toward School _____

Strengths/Weaknesses _____

Extra-Curricular Activities _____

Frequent Absences from School __ Yes __ No If yes, describe _____

Additional Information

_____

_____

_____

_____

_____

Name of Person Completing Form Relationship to Child

TURN PAGE OVER