PSYCH SERVICES OF ROANE COUNTY, INC.
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CHILD INFORMATION FORM
"CONFIDENTIAL"

I. General Information

Date: _____

Child's Name: _____ Nickname: _____

Child's SSN: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Father: _____ Employer: _____

Father's SSN: _____ Occupation: _____

Mother: _____ Employer: _____

Mother's SSN: _____ Occupation: _____

Who referred you here? _____

Address: _____

School & System: _____ Grade: _____ Teacher: _____

Child's Physician: _____

Address: _____

1. What are the problems or difficulties your child is experiencing? _____

_____

2. Have you tried to get any help for this problem or any similar problem elsewhere? ____

If so, where? _____

What treatment was recommended and what were the results? _____

_____

II. Family History

1. Please fill in the names, ages, etc. of your family.

Father _____ Age _____

Mother _____ Age _____

Brothers (oldest to youngest) _____

_____

Sisters (oldest to youngest) _____

_____

Others living at home _____

2. Circle any of the following which have appeared in the family:

Reading Disorder	Birth Defects	Vision Problems
Learning Problems	Cerebral Palsy	Neurological Problems
Allergies	Mental Retardation	Emotional Problems
Migraine Headaches	Epilepsy	Other:
Seizures	Hearing Problems	

3. How long have the child's parents been married to each other? _____

4. Are there any marriage problems between the parents? _____

_____

5. If divorced, does the child get to see his/her father/mother? _____

If so, how regularly? _____

6. Is there anything else you would like the doctor to know about your family situation? _

_____

_____

III. Behavior Problem Checklist

Please circle any of the following which are problems for your child:

Shy	Lacks self-confidence
Over sensitive	Has been in trouble with Juvenile
Disobeys mother	Cries easily
Takes things that are not his/hers	Is irritable
Demand attention	Feels unhappy
Shows immature behavior	Is fearful
Truancy	Is stubborn
Soils himself/herself	Is nervous and jumpy
Bedwetting	Is bossy
Temper tantrums	Is destructive
Misbehaves at home	Has sleeping difficulties
Refuses to share	Has guilt feelings
Nightmares	Headaches
Nail biting	Eating problems
Doesn't tell the truth	Sex problems
Sucks thumb	Complains about going to school
Fears and phobias	Is cruel to animals or pets
Over-dependency	Have morbid preoccupations (Death, etc.)
Jealousy/resentment	Is messy
Cruelty	Is easily frustrated
Is afraid to defend himself	Is overly suspicious
Shows unusual interest in fires	Has suicidal thoughts or behavior
Does not show feelings	Has bizarre or unusual behaviors
Is concerned about neatness	

IV. General Behavior

1. What problems does the child have at home? _____

_____

2. What problems does the child have at school? _____

_____

3. Does your child have difficulty relating to the family? _____

_____

4. Does your child have difficulty relating to his/her teachers? _____

_____

5. Does your child have difficulty relating to his/her peer group? _____

_____

6. How does the child compare with your other children? _____

_____

V. School History

1. Did the child attend nursery school? _____ How many years? _____

2. Does the child like school? _____ Teachers? _____ Classmates? _____

3. Has child frequently been absent from school? _____ Why? _____

_____

4. Best school subject(s) _____

Easiest subject(s) _____

Hardest subject(s) _____

Favorite subject(s) _____

5. What has he/she been hospitalized for in the past? _____

_____

6. Circle any subject presenting difficulty to your child:

Reading Spelling Writing

Language Arithmetic

7. Any grade(s) repeated? _____ Remedial work or tutoring? _____

_____

Does the child like to read? _____ Be read to? _____

Does the child show interest in music? _____ Art? _____

Do you feel the child is working up to potential? _____

_____

Please state any school difficulties. _____

_____

VI. Biomedical History

1. Were there any birth difficulties and/or injuries? _____

   Length of pregnancy: _____ Discoloration? _____

   Birth Weight: _____ Lack of oxygen? _____

   Conditions of newborn: _____ Others _____

2. Age of: Walking: _____ Talking: _____ Toilet Training: _____
3. What aches, pains, or physical discomfort does this child have? _____

   _____

4. Has the child had any of the following? If yes, please state approximate date.

   Hyperactivity _____ Seizures _____ Pneumonia _____

   Ear Discharge _____ Convulsions _____ Head Injuries _____

   High Fever _____ Allergies _____ Hearing problems _____

   Earache _____ Dizziness _____ Feeding problems _____

   Other: _____
5. Has the child ever had an accident or hard fall? _____
6. What medications is he/she taking? _____

   _____

7. When and where was the child's last:

   Vision Exam _____ Results _____

   Hearing Exam _____ Results _____

   Speech Exam _____ Results _____

VII. Parental Impressions

1. Do you think your child has an emotional or learning problem? _____
2. Does it embarrass you that your child has emotional or learning problems? _____
3. Does your wife/husband agree that there are problems? _____
4. Do you feel in part responsible for your child's problems? _____

5. As the child's parent, what concerns you most about him/her? _____

_____

6. At this point, what solutions to your difficulties have you considered? _____

_____

7. Who originated the idea of coming to a psychologist? _____

_____

8. Do you feel that your child would be helped more by:
   a. Talking about his/her problems individually?
   b. A directed program to change specific behaviors?
   c. Psychological or Learning Disability Testing?
   d. Counseling with the teachers?
   e. Group therapy?
   f. Receiving medicine?
   g. Counseling with parents?
   h. Other?

Additional Information: Please tell us any other significant or interesting facts about this child that we may not have asked about. Write on the back of this sheet if you wish.