Rebecca J. Kincaid
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Child History/ Questionnaire

Today's Date:_____

Basic Data:

Name:_____

Date of Birth:_____

Address:_____

_____

Home phone #:_____Cell #:_____

E Mail:_____

Family:

List all members of the household

Name:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If parents are not together give details about noncustodial family:

Noncustodial Parents name:_____

Address:_____

Home phone #:_____ Cell #_____

Parents Employment Information:

Name: Employer and work phone #:

_____ _____

_____ _____

School Information:

School attending:_____

Grade:_____ Primary teacher:_____

Counseler:_____

Other Schools attended and grades attended

_____

_____

School Adjustment:

Summarize current grades:_____

_____

Current school behavior: _____

_____

List any special classes, resource teachers or tutors:

_____

_____

List strengths and weaknesses in specific subjects:

_____

_____

Medical Information:

Physicians Name:_____

Physicians address:_____

Physicians phone number:_____

I give permission for Ms. Kincaid to gather of share information with the above named Physician if necessary: _____
(signature)

Current medications and dosage:

_____

_____

Health Information:

List any past or present illnesses:_____

_____

_____

_____

Present health:_____

_____

Height: _____ Weight;_____ Glasses: Y or N Allergies:_____

Family history of major illnesses:_____

_____

_____

Clinical Information:

Describe the nature of the patient's problems and their duration:

_____

_____

_____

_____

_____

_____

Give a brief account of the patient's history and development of the patient's problems:

_____

_____

_____

_____

_____

Whom have you previously consulted about the patient's current problems? List any speech, cognitive, occupational or any other therapy also:

_____

_____

_____

_____

Circle any of the following that may apply to the patient:

Worries a lot	Excessive hand washing
Cruel to animals	Fighting
Poor sleeper	Tension/Anxiety
Fears	Clinging behavior
Demanding	Defiant
Nightmares	Lying
Nail biting	Stealing
Threatens others	Unhappy
Bed wetting	Restlessness
Talks of death	Twitches
Easily distracted	Threatens suicide
Speech problems	Plays with fire
Makes noises	Soiling themselves
Tantrums	Alcohol or drug use
Poor concentration	Tiredness
Many physical complaints	Was sexually molested
Doesn't like themselves	Smokes cigarettes
Excessive sexual interest/behavior	Odd eating habits

Other: _____

Any significant event in the past 3 years which may have affected the patient

_____

_____

Daily Routine & Interests

Is there any difficulty getting up and to activities in the morning? _____

_____

School attendance issues: _____

_____

_____

What does the child do after school? _____

_____

_____

How much TV and of video games does the child engage in? What type of games or programs?

_____

_____

What percentage of time after school does the child spend with?

Family: _____

Friends: _____

Alone: _____

When and how easily does the child go to bed? _____

_____

_____

List child hobbies, interest, talents and sports:

_____

_____

Friendships & Sibling Information

Does the child make friends easily? _____

_____

_____

What type of friends does your child have? _____

_____

_____

_____

Does your child get along with their siblings? _____

_____

_____

_____

Does your child attend youth activities, clubs or any special group activities regularly? _____

_____

_____

_____

Family History

Describe parents' psychological and medical history: _____

_____

_____

_____

List any significant medical illness in the family and of close relatives:

_____

_____

_____

List any psychological or drug abuse problems or diagnoses of all blood relatives:

_____

_____

_____

List any immediate family members who are either in psychological counseling or are on any medication for mental illness: _____

_____

_____

Any additional information that you would like us to know? _____

_____

_____

_____

_____