# CHILD & FAMILY HISTORY

This form is a method of providing Dr. Ruttenburg with important information about the client (your child) and his/her family in order to provide a more complete picture from which he will assess your child's needs and inform treatment. Please take the time to thoroughly complete this form. The information is confidential with the same privileges and limitation as outlined in the confidentiality section of the intake packet.

## IDENTIFICATION:

Client's Name: ___________________________________________
D.O.B.: ____________________________________________
Form completed by: ________________________________________________________
Today's Date: ____________________________________

.
**What brings you here today?**_____________________________________________________________________________

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
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_____________________________________________________________________________________________________
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_____________________________________________________________________________________________________
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**Goals for Child/Family**

**1.**_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
**2.**_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
**3.**_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

## A. FAMILY:

Blended? ___ Yes ___ No If yes, list dates of family changes, names and roles of adults in child's life.

Father:___________________________________Mother:_________________________________________________
Occupation:______________________________Occupation:______________________________________________
Education:_______________________________Education:______________________________________________
Age:__________________________________Age:___________________________________________________
If separated or divorced list dates: ____________ Who has legal custody? _______________________________

Step-parent or care taker: Step-parent or care taker:

_________________________________________ _______________________________________________

Occupation:____________________________ Occupation:___________________________________

Education:______________________________ Education:___________________________________

Age:___________________________________ Age:_________________________________________

Date joined family:______________________ Date joined family:___________________________

Step-parent or care taker: Step-parent or care taker:

________________________________________ _____________________________________________

Occupation:____________________________ Occupation:__________________________________

Education:______________________________ Education:___________________________________

Age:___________________________________ Age:_________________________________________

Date joined family:______________________ Date joined family:___________________________

Siblings:

Indicate if: biological (B), step (S), half (H) sibling to the client.

| Name | Age: | Sex: | In or out of the home: |
|---|---|---|---|
| ________________________________ | Age:________ | Sex:_________ | In_____Out_____ |
| ________________________________ | Age:________ | Sex:_________ | In_____Out_____ |
| ________________________________ | Age:________ | Sex:_________ | In_____Out_____ |
| ________________________________ | Age:________ | Sex:_________ | In_____Out_____ |
| ________________________________ | Age:________ | Sex:_________ | In_____Out_____ |
| ________________________________ | Age:________ | Sex:_________ | In_____Out_____ |

**BIRTH OF YOUR CHLD: (circle all that apply)**

Planned Unplanned Wanted Unwanted

Did mother see her physician regularly? ____Yes ____No How often?____________________

How far along was the pregnancy when mother realized she was pregnant?___________________

Prior to the pregnancy mother used: **(Circle)**
Tobacco Alcohol Caffeine
Over-the-Counter Medications
Prescription Medications
Marijuana Other drugs

During the pregnancy mother used: **(Circle)**
Tobacco Alcohol Caffeine
Over-the-Counter Medications
Prescription Medications
Marijuana Other drugs:______________

List the names of drugs used during pregnancy, how ingested, frequency and amount of use:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Was the pregnancy normal? ____Yes ____No (if no describe)

______________________________________________________________________________

______________________________________________________________________________

Was the birth normal? ____Yes ____No (if no describe)

______________________________________________________________________________

______________________________________________________________________________

Length of pregnancy: ____________________Length of labor:_________________________

Birth weight: __________________________Birth length:____________________________

List any abnormalities. (i.e., medications the baby needed, illness, physical defects, etc.)

______________________________________________________________________________

______________________________________________________________________________

Location of birth. I.e. name of hospital or other location, city, state, country:

______________________________________________________________________________

______________________________________________________________________________

**FIRST YEAR**: How would you describe your child?

Activity level: **(circle)**

Constantly moving Moderately active Inactive

When faced with change: **(circle)**

Easily upset took time to adjust Quick to adapt

In an emotional situation (pleasant or unpleasant) reaction was: **(circle)**

Intense Moderate Bland

In most situations, baby's mood was: **(circle)**

Cheerful Variable Negative

The time span the baby focused attention on one thing was: **(circle)**

Long Moderate Short

Was the baby cuddly? ____Yes ____No

Patterns during first year: **(Circle all that apply)**

Colic Allergies Frequent vomiting Frequent/prolonged crying Sleeping problems

Was your child breast-fed? ____No ____Yes Up to what age? ______________________

**Please check and date any concerns in the following milestones:**

___________ Respond to sound

___________ Stand alone

__________ Crawl

__________ Give up bottle

__________ Dress self

_____________Use first clear words

_____________Use cup/spoon

_____________Walk alone

_____________Remain dry during day

_____________Remain dry at night

_____________Complete bowel training

What hand does the child prefer? **(circle)** Right Left Both

Coordination is: **(circle)** Poor Average Good

## B. HEALTH INFORMATION:

Who is your child's primary care provider (Doctor, P.A., Etc.)?___________________________

When was your child's last physical?________________________________________________

Does your child have any chronic health problems, including allergies? ____Yes ____No

If yes list conditions and interventions/treatments________________________________

______________________________________________________________________________

______________________________________________________________________________

Is he or she currently taking and medications? ____Yes ____No

If yes list prescribing physician, name of medication, amounts and how long has he or she been on the medications_____________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Has your child ever suffered from a head injury? ____Yes ____ No

If yes explain the injury, treatment and approximate date______________________________________

______________________________________________________________________________

Has your child ever met with a mental health therapist or drug and alcohol therapist? ____No ____ Yes

If yes with whom, where, when, duration of treatment, reason for treatment and outcome.____________

______________________________________________________________________________

**NOTE: Limits on confidentiality which may need to be reported to authorities: history of abuse or imminent danger to self or others.**

Past or current Challenges for your child:

| | |
|---|---|
| Sad | Fear from traumatic experience |
| Anxiety | Panic Attack (intense fear) |
| Anger Problem | Avoidance of going places due to fear |
| Tantrums | Oppositional |
| Cries easily | Isolates |
| Hallucinations | Phobias |
| Obsessive/Compulsive | Paranoia |
| Mood Swings | Problems Sleeping |
| Self harm | Suicidal Thoughts |
| Harming others | Homicidal Thoughts |
| Hyperactivity | Attention problems |
| Impulsive | Lack of remorse/empathy |
| Fire setting | Cruelty to animals |
| Sexualized behavior | Excessive computer use |
| Victim of sexual abuse | Victim of physical abuse |

Other: ______________________________________________________________________

List any family history of mental illness (e.g.; depression, anxiety, schizophrenia, hospitalization, etc.)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

List any legal involvement your child has had and if he or she is currently involved with the law including involvement with Services to Children & Families.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please list any concerns regarding computer or screen time regarding your child.

______________________________________________________________________________

______________________________________________________________________________

Has your child experimented with or had problems with drugs and/or alcohol to your knowledge?

_____Yes _____No If yes, explain.

______________________________________________________________________________

__________________________________________________________

List any family history of problems with drugs or alcohol. ______________________________________________

______________________________________________________________________________

______________________________________________________________________________

List any major family changes, stressors or family values that you believe impact your child.

______________________________________________________________________________

______________________________________________________________________________

List any religious and/or cultural beliefs practiced in the home. _________________________________

______________________________________________________________________________

List some of your child's strengths. _____________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## C. SCHOOL INFORMATION:

Name of school:_______________________________

Name of teacher:______________________________

Grade in school:_______________________________

Is your child working at grade level? ____Yes ____ No

If no explain. _______________________________________________________________

______________________________________________________________________________

Have there been any major changes in the grades of your child receives? ____Yes ____No

If yes explain:_______________________________________________________________

______________________________________________________________________________

Has your child ever received special classes or been on an Individual Education Plan? ____ Yes ____ No

Talented & Gifted Program? ____ Yes ____ No

If yes explain and provide years and types of services: ___________________________________

______________________________________________________________________________

______________________________________________________________________________

Has your child received referrals or been suspended from school? ____ Yes ____ No

If yes, when, what caused the suspension/referral, how many times has he/she been suspended or referred? ___________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Has your child ever repeated a grade? ____ Yes ____ No

If yes, which grade and how did he or she respond? ____________________________________________

______________________________________________________________________________

______________________________________________________________________________

How does your child get along with other children at school? Good Fair Poor

How does your child get along with teachers at school? Good Fair Poor

List your child's strengths at school: __________________________________________________

**ADDITIONAL INFORMATION YOU BELIEVE MAY BE HELPFUL TO YOUR CHILD'S TREATMENT:** ________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Thank You