Boller Psychological Services, LLC

Phone: 801-661-1992

History Form: Child

Please print, complete, and bring to Dr. Boller prior to your first appointment. This is an important part of your child's intake assessment, and is held to the same level of confidentiality as therapy.

Date:___________________________________

Child's Full Legal Name:____________________

Date of Birth:________________ Age:______________

Current Grade:____________________ School:___________________________

Child Currently lives with: ___________________________

Siblings and ages:____

Family Address(include Street Address/City/State/ Zip Code):

____

Who has legal custody if parents are divorced?_______________________________

Primary email:____

Phone (mother) Home:____________ Cell:________________Work:____________

Phone (father) Home:____________ Cell:________________Work:____________

Can we leave a message_________yes__________no If yes, which number?

Emergency Contacts:____

Person Completing Form:__________________Relationship to Child:_____________

Preferred Way of Contact:

Note: Email and texts are not secure forms of communication.

Specify mode of contact preferred:_______________________________________

Referred to Dr. Boller by:____

What are your child's strengths:

What concerns you most about your child?:

What are your goals for treatment?:

P.2 Child History Form

Family History

Is there any history of the following in the child's biological relatives

Mother's side of family:

______Learning Problems __________School Problems ________ADHD
______Anxiety __________Obessive-Compulsive Disorder
______Depression ___________Tourette Syndrome
_______Picking/Hair Pulling _______Alcoholism/Drug Abuse
_______ Autism Spectrum __________Bipolar Disorder
_______Genetic Disorder__________Metabolic Disease _________Other(specify)

Is there any history of the following in the child's biological relatives:

Father's side of family:

______Learning Problems __________School Problems ________ADHD
______Anxiety __________Obessive-Compulsive Disorder
______Depression __________Tourette Syndrome
_______Obsessive Picking/Hair Pulling _______Alcoholism/Drug Abuse
_______ Autism Spectrum ______________Bipolar Disorder
_______Genetic Disorder__________Metabolic Disease _________Other

Have any of your child's biological relatives experienced problems similar to those your child is experiencing? If so, please describe:

Describe any problems between patient and siblings:

Describe overall, general family relationships:

Pregnancy and Birth History:

How many weeks did pregnancy last?
If birth was premature, please explain (include any complications):

Please describe reason for and medical interventions/hospitalizations following birth:

P. 3 : Child History Form

Developmental History:

List age for each milestone achieved. Approximate if unsure:

Crawled _______________ Walked____________ First words:______________

First Sentences:_______Toilet Trained (night):___________Toilet Trained (Day)________

Please describe any difficulties with any of the above milestones:

Did your child exhibit any of these behaviors in the pat, but no longer does? Please circle all that apply:

Difficult to calm/pacify Irritability/easily agitated Did not like to be held
Clumsy/uncoordinated Highly active Difficulty making eye contact
Staring or avoiding looking at things Rocking or head bangining
Walking on tiptoes Unusual play behaviors Flapping hands or spinning
Difficulty interacting with others Shy
Poor eye contact

Explanations/Early interventions/Pediatric Assessment:

Current Symptom Checklist

Please circle the behaviors your child CURRENTLY EXHIBITS to a heightened degree that it interferes with success at school, home, extra-curricular activities or friends:

High Activity Impulsive Behavior (poor self control) Interrupts Frequently
Poor Attention Span Acts as if “driven by a motor” Difficulty Finishing Tasks
Disorganized Low frustration tolerance Aggressive
Temper Outbursts Does not seem to listen Difficulty with sleep
Daytime accidents Bedwetting Worried/anxious
Problems with multi-step directions Does not think logically Poor awareness of time
Problems understanding jokes Problems expressing self
Talking around issues, doesn’t come to a point Does/says things repeatedly
Problems changing activities or making transitions
Difficulty with unexpected changes in schedule Pulling out own hair, picking
tics/twitching drugs/substance abuse Cruelty to animals
Vandalism/stealing Lying/cheating Trouble making friends
Poor eye contact

P. 4 : Child History Form

Difficulties with:

Self Harm (please explain):

Concerns about diet/eating (please explain):

History of sexual or physical abuse (please briefly explain):

Which specific behaviors interfere with family functioning?

Parenting Styles:

How would you describe your parenting style? Do both parents agree on type of discipline to use?

Is discipline effective? Yes No (if no, please explain)

Friendships and Social Skills

What are your child's strengths in social relationships outside the family?(describe):

Do other children seek out your child to socialize? Yes No

Does your child relate well to other children? Yes No

Does your child seem to understand the rules of social interaction? Yes No

Does your child report feeling lonely? Yes No

Has your child been described as: Bossy? Withdrawn? Disinterested in friends?

Are your child's friends: Same age Older Younger

Please circle any areas of difficulty with peers:

initiating play	Making new friends	Keeping old friends	Group Play
Compromising	Sharing	Being accepted	Individual Play

Please explain any concerns you have about your child's friendships or lack of them:

What does your child enjoy doing most?

What does your child dislike doing that is part of their daily life?

P.5 Child History Form

Does your child participate in sports activities? No Yes (Describe)

Does your child participate in other extracurricular activities (art, music,lessons, etc.)
No Yes (Describe)

Academic History

Did/does your child receive Early Intervention?	No	Yes
Does your child enjoy school?	No	Yes

Has your child ever been held back or has retention ever been suggested?
If yes, please explain:

Circle any problems reported by your child's current teacher:

Daytime sleepiness	Attention/concentration	Distractibility
Hyperactivity/impulsivity	Aggression	Oppositional behavior
Poor Memory	Following directions	Not turning in assignments
Doesn't get along well	Withdrawal	Few friends
Anxious	Sad	Angry
Handwriting	Reading/Math problems	Other:

Describe the process of doing homework each night with your child:

Present Medical Status

Is your child healthy overall?
Current medical problems for which your child is being treated (include medications):

Does your child have any difficulties with sleep?
If so, does he/she (circle all that apply):

Awakens in middle of night	Nightmares (how often)	
Struggles to fall asleep	Moves excessively in sleep	Sleepwalks
Night Terrors (how often, has pediatrician assessed?)		
Snores	Appears tired in the day or takes naps	

Has your child ever been in therapy before?If yes, complete the following:

Therapist(s) name:	Duration of treatment(s):
Diagnosis:	Response to treatment/outcome:

Comments about past therapy:

Has your child had psychological testing done? When/by whom?
*Please attach an assessments

P.6 Child History Form

Adoption Addendum (Please skip if this does not apply)

Age at adoption: Country/State of birth:

Foster placements prior to adoption? Yes No

If yes, please describe:

Please describe any concerns at the time of adoption:

Please circle all that apply to your adopted child:

History of abuse | History of Neglect | Drug/Alcohol use by biological mother

Social Withdrawal | Over-friendly with Strangers