1215 Louisiana Ave., Suite 100, Winter Park, FL 32789
(407) 622-0825 fax (407) 622-0826
www.drrobinmeade.com

Robin Meade, Psy.D.
Licensed Psychologist
Licensed Mental Health Counselor
Certified Family Mediator

Child History Form

Please provide the following information regarding your child. Note: The information you provide here is protected as confidential information.

Please fill out this form completely and bring it to your first session.

Last Name: _____ First Name: _____ Middle Initial___

Name Your Child Would Like to Be Called (Nickname): _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Name of person completing form: _____ Relationship: _____

Street Address: _____

City _____ State _____ Zip _____

Home Phone: (_____) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: (_____) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Emergency Contact (Nearest relative not living at patient address above):
Name: Address: Relationship: Phone:

_____

Who referred you? _____

Parent/Legal Guardian Driver's License No. & State: _____

YOUR CHILD'S FAMILY:

Parent's Name: _____ Age: _____

Occupation: _____ Health: _____ Phone number: _____

If deceased, cause of death: _____

Parent's Name: _____ Age: _____

Occupation: _____ Health: _____ Phone number: _____

If deceased, cause of death: _____

With whom does the child live? _____

Sibling Names, Ages, School Attending or Occupation: _____

_____

Other parent's address if applicable: _____

_____

Please list your child's grade and school attending: _____

What is your child's attitude toward school: _____

Does your child have an adequate quantity and quality of friendships? Please explain: _____

_____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ Yes □ No

If Yes, previous therapist/practitioner: _____

What social agencies are involved in your case? _____

_____

Are you or your immediate family currently involved in any legal proceeding(s)? (i.e.: divorce, criminal, civil related issue(s)?_____

_____

If yes - name and contact information of attorney:_____

_____

What made you seek help at this time? _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION:

1. How would you rate your child's current physical health? (please check one)

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very good

Please list any specific health problems your child is currently experiencing:

_____

_____

2. At what age did your child reach these developmental milestones: Turned over _____
Sat alone _____ Crawled _____ Weaned _____ Spoke first words _____
Walked _____ Talked in sentences _____ Fed self _____ Tied own shoes _____
Toilet trained _____

3. Has your child ever been prescribed psychiatric medication? □ Yes □ No

4. Please list all current medications and the physician who prescribed them:

_____

_____

5. Has your child ever been hospitalized? ☐ Yes ☐ No If yes, please provide details:

Date	Location	Reason	Outcome

_____

_____

_____

6. Pediatrician's Name: _____ Phone Number: _____

7. Has he/she ever had a head injury? ☐ Yes ☐ No
When and describe: _____

8. Has he/she ever lost consciousness? ☐ Yes ☐ No
When and describe: _____

9. How would you rate your child's current sleeping habits? (please check one)

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems he/she is currently experiencing (e.g. trouble falling asleep or waking up; snoring; restless sleep; breathing problems; waking up frequently; nightmares; sleepwalking; bedwetting):

_____

10. Please list any difficulties your child is experiencing with his/her appetite or eating patterns:

_____

11. Is your child currently experiencing overwhelming sadness, grief or depression? ☐ Yes ☐ No
If yes, for approximately how long? _____

12. Is your child experiencing anxiety, panic attacks or have any phobias? ☐ Yes ☐ No
If yes, when did your child begin experiencing this? _____

13. What significant life changes or stressful events has your child experienced recently?

_____

_____

_____

ABUSE/TRAUMA:

Has your child ever been physically/sexually/emotionally abused? ☐ Yes ☐ No

Alleged abuser(s): _____

At what age(s): _____ How did this affect your child?_____

_____

Has your child ever experienced any other severe trauma? ☐ Yes ☐ No If yes, explain how child was affected:_____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

Family History:	**Check one:**	**Family Member Relationship:**
Alcohol/Substance Abuse	☐ Yes ☐ No	_____
Anxiety	☐ Yes ☐ No	_____
Depression	☐ Yes ☐ No	_____
Domestic Violence	☐ Yes ☐ No	_____
Eating Disorders	☐ Yes ☐ No	_____
Obsessive Compulsive Behavior	☐ Yes ☐ No	_____
Psychiatric Hospitalizations	☐ Yes ☐ No	_____
Schizophrenia	☐ Yes ☐ No	_____
Suicide Attempts	☐ Yes ☐ No	_____

Has someone in your family ever been arrested? ☐ Yes ☐ No

Name	Relationship to Your Child	What Charges	Outcome

Anything else not covered above?_____

_____

_____

_____ _____

Parent/Legal Guardian Signature Date Completed