Child History Form

Name:	Age:
School:	Grade:
Mother's Name:	Father's Name:
Who has custody of child?	Family Doctor:
Child Medication List:	
Are parents married?	☐ YES ☐ NO
Are parents separated/divorced?	☐ YES ☐ NO If yes, what age?
Are any stepparents or parent significant involved?	☐ YES ☐ NO
Any issues during pregnancy?	☐ YES ☐ NO
Any issues during the first 3 years of the child's life?	☐ YES ☐ NO
Did the child walk, talk, etc. on time?	☐ YES ☐ NO
Any issues transitioning to school?	☐ YES ☐ NO
Does the child have health issues? (Past and current)	☐ YES ☐ NO
Has the child experienced any major losses, changes, or deaths?	☐ YES ☐ NO
Has any friends or family of the child ever attempted/completed suicide?	☐ YES ☐ NO
Has the child experienced any known or suspected physical, sexual, or emotional abuse?	☐ YES ☐ NO
Any previous mental health treatment (therapy, medication)?	☐ YES ☐ NO
Has the child been hospitalized for mental health or substance abuse issues?	☐ YES ☐ NO
Does the child have siblings?	☐ YES ☐ NO If yes, please list biological and stepsiblings by both parents and their ages.

Client Signature | Parent/Guardian Signature

Relationship

Witness Signature | Date

2121 7th St., Parkersburg, WV, 26101

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