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CHILD AND FAMILY INFORMATION SHEET

Child's name _____ Birthdate _____ Age _____ M/F

Address _____
(Street) (City) (State) (Zip)

Father's name _____ DOB _____ SSN _____
(if different)

Address _____ Phone _____
(Street) (City) (State) (Zip)

Father's place of employment _____

E-mail appointment information yes/no (email address) _____

Mother's name _____ DOB _____ SSN _____
(if different)

Address _____ Phone _____
(Street) (City) (State) (Zip)

Mother's place of employment _____

E-mail appointment information yes/no (email address) _____

Referral Source: _____

Child's school _____ Teacher's name _____

School Address _____ Phone _____
(Street) (City) (State) (Zip)

Is your child in special education? Yes No If yes, what kind of program? _____

Are parents married? Yes No Separated? Yes No Divorced? Yes No

Is your child adopted? Yes No If yes, age when adopted _____

Child's PCP _____ Phone _____ Fax _____

Physician's address _____
(Street) (City) (State) (Zip)

Ethnicity: _____

Spirituality: _____

Please list other physicians who currently and regularly care for your child:

Name

Address and Phone

(If you would like information shared with anyone named above (i.e., school, doctors) please fill out a release form)

FAMILY MEMBERS: (list family members living together)

Last Name	First Name	Age	Gender	School Grade or Occupation	Relationship to Patient

OTHER FAMILY MEMBERS: (list other important family members)

Last Name	First Name	Age	Gender	School Grade or Occupation	Relationship to Patient

List important family events, such as deaths, divorce or separation, shifts of location or employment, etc: _____

PRENATAL/BIRTH HISTORY:

Complications during pregnancy _____ Length _____ weeks

Complications during delivery _____

Complications while in hospital/early infancy _____

Other prenatal birth information _____

EARLY DEVELOPMENTAL MILESTONES:

When did your child:	Early	Average	Late
Sit without help	_____	_____	_____
Crawl	_____	_____	_____
Walk alone without assistance	_____	_____	_____
Use single words (such as, "mama," "dada," "ball")	_____	_____	_____
Put two or more words together (such as, "mama up")	_____	_____	_____
Accomplish Bowel training, day and night	_____	_____	_____
Accomplish bladder training, day and night	_____	_____	_____

EARLY HEALTH AND TEMPERAMENT:

During infancy/toddler years was your child:

- Difficult to feed Yes/No
- Difficult to get to sleep Yes/No
- Colicky Yes/No
- Difficult to put on a schedule Yes/No
- Alert Yes/No
- Cheerful Yes/No
- Affectionate Yes/No
- Sociable Yes/No
- Easy to comfort Yes/No
- Difficult to keep busy Yes/No
- Ovcractive, in constant motion Yes/No
- Very stubborn, challenging Yes/No

MEDICAL HISTORY

Please describe any serious medical conditions, surgeries, head injuries, hospitalizations or accidents your child has had and at what age: _____

Please describe any current medical conditions your child is being treated for?

Condition _____ Treatment/medications _____

Please describe any history or current medical conditions in the family? _____

MENTAL HEALTH HISTORY:

Has your child ever participated in inpatient treatment? Yes/No

Where	Child's age	Reason	Length of stay	Effective yes/no

Has your child ever participated in outpatient treatment?

Where	Child's age	Reason	Length of stay	Effective yes/no

Please describe any history or current mental health conditions in the family? _____

SUBSTANCE ABUSE HISTORY:

Does your child use any alcohol or drugs? Yes/No

<u>Substance</u>	<u>type</u>	<u>Route (oral, inhaled, injected)</u>	<u>Frequency amount</u>	<u>First used</u>	<u>Last used</u>
Alcohol					
Alcohol					
Drugs					
Drugs					
Drugs					

List any consequences of your child/ adolescents substance use (ie; lowered grades, school problems, legal problems, behavioral problems, medical problems etc) _____

List any previous substance abuse treatment:
 None _____ Inpatient _____ when/where? _____

Outpatient _____ when/where? _____

Support groups (AA etc) _____ when/where? _____

Is there any family history of substance abuse? Yes or No Who? _____

CURRENT FUNCTIONING STRENGTHS:

What are your child's interests, hobbies, extra-curricular activities? _____

What are your child's strengths? _____

Please rate your child:

	Above average	Average	Below Average
Gross motor skills (ie, running, throwing)	_____	_____	_____
Fine motor skills (ie, writing, cutting)	_____	_____	_____
Attention	_____	_____	_____
Impulse control	_____	_____	_____
Academic skills	_____	_____	_____
Expressive language (speaking)	_____	_____	_____
Receptive language (listening, understanding)	_____	_____	_____
Social skills	_____	_____	_____
Aggression	_____	_____	_____
Emotional control	_____	_____	_____
Eating habits	_____	_____	_____
Sleep habits	_____	_____	_____
Other areas you observe difficulties:	_____	_____	_____

NEEDS:

What are your chief concerns regarding your child? _____

What are your child's chief concerns? _____

What are your goals for your child's evaluation/ treatment? _____

What are your child's goals? _____

This information provided by:

(Signature)

(Date)

Reviewed in initial interview by:

(Clinician)

(Date)

Please bring copies of any documents (i.e., school reports, previous psychological evaluations, IEPs, legal papers, etc) that would help us get to know your child better to your initial interview.

We look forward to meeting with you!