PASCHAL, MINCY, CLARK, HOROWITZ, & HOULIOS M.S.W.
Licensed Clinical Social Workers
2888-4 Mahan Drive
Tallahassee, FL 32308
(850) 385-9046
Fax (850) 385-9401

The information you provide on this form will be held in strict confidence and will be used in planning your child's treatment. Please answer all questions. Thank you for your help.

Date:_____ Name of Child: _____ Age:_____ Sex: _____

I. MEDICAL INFORMATION - Please check any of the following which describe your child now.

1. SLEEP PATTERNS: Does your child:

_____ sleep too much
_____ sleep too little
_____ have difficult falling asleep
_____ have frequent nightmares
_____ wake often or early
_____ sleepwalk or wander
_____ none of the above

2. EATING PATTERNS: Does your child:

_____ have a special diet
_____ have normal eating habits
_____ overeat
_____ have poor eating habits
_____ have an eating problem: _____
_____

3. MEDICAL HISTORY: Please check any of the following which are or have been a health problem for your child.

_____ Skin Disorder
_____ Sight, Speech, Hearing Problems
_____ Limb Paralysis, Lameness, etc.
_____ Seizure Disorder/Fits/Convulsions
_____ Gland Problems
_____ Cancer, Tumors
_____ Breathing Problems/Asthma
_____ Dizziness, Fainting
_____ Fever Above 104°
_____ Fever Lasting More Than 5 Days
_____ Frequent Headaches
_____ Loss of Consciousness
_____ Physical Handicaps/Limitations
_____ Menstrual Problems (for girls)
_____ Gets Sick Often
_____ Excessive Bleeding/Clotting Problem
_____ Drugs
_____ Other (Specify) _____
_____
_____ Alcohol
_____ Fatigue - unusual, persistent
_____ Heart Disorder
_____ Blood Pressure
_____ Stomach Ulcers/Indigestion
_____ Vomiting - frequent, unusual
_____ Bowel Problems/Diarrhea/Colitis
_____ Kidney, Bladder Problems
_____ Genitourinary Problems
_____ Sugar Disorder, Diabetes, etc.
_____ Arthritis
_____ Sinus Problems
_____ Allergies
_____ Head Trauma
_____ Broken Bones
_____ Other Significant Accidents or Injuries: ____
_____

4. LIST ANY MEDICAL HOSPITALIZATION YOUR CHILD HAS HAD OR SPECIAL DOCTOR YOUR CHILD HAS SEEN.

Date	Location	Reason

5. PLEASE LIST ANY MEDICATIONS YOUR CHILD IS NOW TAKING (prescription and non-prescription, including aspirin, nasal spray, etc.).

Name of Medication	Prescribing Physician	How Much	How Often	How Long

6. IS S/HE EXPERIENCING ANY SIDE EFFECTS FROM ANY MEDICATION? IF YES, PLEASE EXPLAIN.

7. HAS YOUR CHILD HAD ANY PROBLEMS WITH ANY PREVIOUS MEDICATION TAKEN? IF YES, PLEASE EXPLAIN.

8. LIST BELOW ANY PREVIOUS MENTAL HEALTH SERVICES YOUR CHILD HAS RECEIVED.

Where	Reason	Dates From-To	Results

9. HOW WOULD YOU RATE YOUR CHILD'S GENERAL PHYSICAL HEALTH?

_____ POOR _____ FAIR _____ GOOD _____ EXCELLENT

10. NAME OF CHILD'S PHYSICIAN: _____
PHONE NUMBER: _____

11. DATE OF LAST MEDICAL EXAMINATION: _____
Child's Current Weight: _____ Child's Current Height: _____

II. FAMILY HISTORY

1.

CHILD'S FAMILY	NAME	AGE	EDUC.	OCCU-PATION	DOES PERSON LIVE IN HOME
Father					
Mother					
Step/Foster Father					
Step/Foster Mother					
Brother/Sister(s)					
" "					
" "					

2. IF THE CHILD WAS NOT RAISED BY BOTH NATURAL PARENTS, PLEASE EXPLAIN.

3. IN HOW MANY PLACES HAS THE FAMILY LIVED SINCE THE CHILD'S BIRTH?

Place	How Long	Age of Child

4. LIST ANY IMPORTANT PERSON(S) IN YOUR CHILD'S LIFE AT THIS TIME.

5. IF YOUR CHILD HAS EXPERIENCED ANY OF THE FOLLOWING, INDICATE YOUR CHILD'S AGE AT THE TIME OF THE INCIDENT.

Incident	Age of Child
Death of significant other	
Physical abuse	
Sexual abuse	
Long-term financial instability	
Hospitalization of a parent	
Divorce/Separation of parents	
Alcohol/Drug abuse by parent	

6. LIST ANY FAMILY MEMBERS WHO HAVE RECEIVED MENTAL HEALTH SERVICES.

Who	When	Where	Reason

III. CHILD'S DEVELOPMENT

1. PRENATAL HISTORY

What was the length of the pregnancy? _____
Were there any problems during the pregnancy or birth? _____
Did the mother take any drugs or medications during pregnancy? _____
Did the mother drink alcohol during pregnancy? _____
Did the mother smoke during pregnancy? _____

2. INFANT/TODDLER HISTORY

At approximately what age did your child talk? _____
At approximately what age did your child walk? _____
At approximately what age was your child toilet trained? _____

DURING THE FIRST THREE YEARS OF LIFE DID YOUR CHILD:

Enjoy being held? _____ Appear overly active? _____
Appear to be a happy baby? _____ Have a change in primary caretaker? _____

IV. CHILD'S EDUCATION

1. PRESENT SCHOOL: _____Grade: _____
   School Address: _____Phone:_____
   Name of school personnel to be contacted about your child: _____

2. HAS YOUR CHILD EVER ATTENDED A SPECIAL EDUCATION PROGRAM: _____Yes _____No
   If so, is your child in a special education class now? _____Yes _____No

3. HOW WELL IS YOUR CHILD DOING IN CLASSWORK AND CLASSROOM BEHAVIOR?

4. IS THIS A CHANGE FROM THE PAST?

5. EXPLAIN IF THERE HAVE BEEN ANY GRADES CHILD SKIPPED OR REPEATED, OR ANY INTERRUPTIONS IN HIS/HER EDUCATION.

6. WHAT, IF ANY, BEHAVIORAL OR ATTENDANCE PROBLEM HAS YOUR CHILD HAD AT SCHOOL?

V. MANAGEMENT OF YOUR CHILD

1. HOW DO YOU DISCIPLINE YOUR CHILD? HOW WELL HAS THIS WORKED?

2. HAS YOUR CHILD EVER BEEN INVOLVED WITH THE POLICE? If yes, how?

3. DOES YOUR CHILD HAVE A PAROLE/PROBATION OFFICER OR HRS WORKER? If yes, please give the following:

Name of Worker	Parole/Probation or HRS	Phone

VI. ACTIVITIES/INTERESTS

1. WHAT DOES YOUR CHILD ENJOY DOING FOR FUN?

2. WHAT KIND OF THINGS DO YOU DO TOGETHER WITH THE CHILD?

   Father:

   Mother:

   As a Family:

VII. DESCRIBE THE AREAS WITH WHICH YOU WOULD LIKE TO HAVE HELP AT THIS TIME.

SIGNATURE OF PERSON COMPLETING: _____ Date: _____
Relationship to child: _____ Home Phone: _____
Address: _____ Work Phone: _____
_____
_____