Insight Psychology, LLC

Child Medical History Questionnaire

Child's Name: _____ Birthdate: _____

Your Name: _____ Today's Date: _____

MEDICAL HISTORY

Child's birth weight _____ lbs, _____ oz. Length of pregnancy: _____ weeks.

Were there any complications during pregnancy (i.e., medical problems, high level of stress, etc.)?
_____ NO _____ YES
If so, what were they?

_____

_____

Were there medical problems during birth? _____ NO _____ YES
If so, what were they?

_____

_____

Were there medical problems during the child's first year? _____ NO _____ YES
If so, what were they?

_____

_____

Does your child have a history of:

Hospitalization	____ NO ____YES	Allergies	____ NO ____YES
Head injury	____ NO ____YES	Asthma	____ NO ____YES
Seizure	____ NO ____YES	Vision problems	____ NO ____YES
Poisoned	____ NO ____YES	Hearing problems	____ NO ____YES
Many ear infections	____ NO ____YES	Speech problems	____ NO ____YES
Poor coordination	____ NO ____YES	Difficulty walking	____ NO ____YES
Sleep problems	____ NO ____YES	History/Current	
Eating problems	____ NO ____YES	bed wetting	____ NO ____YES
		bed soiling	____ NO ____YES

DEVELOPMENTAL MILESTONES

Please record the approximate age at which your child first did the following:

	Approx. Age Achieved	Not Yet	Don't Remember
Walked without help	_____	_____	_____
Spoke first words other than "mama" or "dada"	_____	_____	_____
Spoke in 2-3 word sentences	_____	_____	_____
Toilet trained—daytime	_____	_____	_____
Toilet trained—nighttime	_____	_____	_____
Rode bicycle without training wheels	_____	_____	_____
Tied own shoes	_____	_____	_____

Circle the speed at which you think your child has developed, overall:

SLOW NORMAL RAPID

PRESENT MEDICAL STATUS

Current health (poor, good, excellent):

_____

Significant past illnesses:

_____

_____

_____

Illnesses for which your child is currently treated: _____

_____

_____

Physical problems your child reports:

_____

_____

Medications your child is currently taking (dosage, frequency, length on medication): _____

_____

_____

_____

Child's Physician: _____ Child's Psychiatrist: _____

In the past 6 months, has there been a change in your child's weight, appetite, or sleep? NO YES
If yes, please explain:

_____

_____

Has your child ever been involved in any type of professional mental health treatment? NO YES
If yes, please list the name of the therapist, length of therapy, reason for therapy, and years when this occurred:

_____

_____

_____

FAMILY MEDICAL HISTORY

We are interested in whether anyone in your family, other than this child, has or has had any of the conditions listed. Please put an X in the column of the family member(s) who have or have had each problem.

	Child's mother	Child's father	Child's brother(s)	Child's sister(s)	Child's grandfather(s)	Child's grandmother(s)	Other: (please specify)
Hyperactive as a child							
Repeated a grade in school							
Speech Problems							
Seizures							
Mental Retardation							
Behavioral Problems in Childhood							
Trouble with the law							
Depression							
Eating Problems							
Anxiety problems							
Schizophrenia							
Other emotional problems							
Drinking problem							
Drug problem							
Serious health problems							
Other:							