BROUDY AND ASSOCIATES

Child Data Form

CHILD'S NAME_____ **D.O.B.**_____ **M**____**F**____

SOC. SEC. #_____ **HOME PHONE #**_____

ADDRESS_____

SCHOOL_____ **GRADE**_____

MOTHER'S NAME_____ **SOC. SEC. #**_____

ADDRESS (if different from child's) _____

TELEPHONE #_____

EMPLOYER_____ **PHONE #**_____

FATHER'S NAME_____ **SOC. SEC. #**_____

ADDRESS (if different from child's) _____

TELEPHONE #_____

EMPLOYER_____ **PHONE #**_____

WHO HAS CUSTODY OF CHILD? _____

OTHER FAMILY MEMBERS IN THE HOME:

NAME	AGE	RELATION

OUTSIDE THE HOME

NAME	AGE	RELATION

DEVELOPMENTAL HISTORY

Pregnancy: **Duration_____ months**

Complications (illness, infections, medications taken) _____

History of alcohol or substance abuse? _____

Delivery: **Birth Weight _____lbs._____oz.**

Type of Delivery: **Head First_____ Breach_____**

Complications: **Cord around Neck_____ Cord Presented First_____**

Hemorrhage_____ **Infant injured during delivery (Explain) _____**

Other (Specify) _____

Post Delivery Period (While In hospital): _____Cry: Immediate____ Delayed____ How Long? _____

Infection (Specify) _____

Birth Defects (specify) _____

Infancy/Pre-School Period:
Were any of the following present during the first years of life? If so, check.
Did not enjoy cuddling_____ Not calmed by being held and/or stroked_____ Colic_____
Excessive Restlessness_____ Sleep Problems_____ Frequent Head Banging_____
Constantly into everything_____ Excessive # of Accidents compared to other Children_____

Developmental Milestones:
Please record the approximate age at which your child reached the following developmental Milestones:

	Approximate Age
Crawled	_____
Walked without Assistance	_____
Spoke first words besides "ma-ma" and "da-da"	_____
Said sentences	_____
Bowel trained, day	_____
Bowel trained, night	_____
Bladder trained, day	_____
Bladder trained, night	_____

Coordination
Rate your child on the following skills:

	Good	Average	Poor	N/A
Running	_____	_____	____	____
Throwing	_____	_____	____	____
Catching	_____	_____	____	____
Writing	_____	_____	____	____

Intelligence and Understanding

Do you consider your child to understand directions and situations as well as other children his or Her age? _____ If not, why not? _____

EDUCATIONAL HISTORY (IF APPLICABLE)

Rate your child's school experience related to academic learning:

	Good	Average	Poor	N/A
Current Grade	_____	____	____	____
Previous Grade	_____	____	____	____
Pre-School/Daycare	_____	____	____	____

To the best of your knowledge, at what grade level is your child functioning? Reading_____ Spelling_____ Arithmetic_____

Has your child ever had to repeat a grade? _____ If so, which? _____

Present class placement: Regular Class_____ Special Class (Specify) _____

What kinds of special help or remedial work is your child currently receiving? _____
_____

Describe briefly any academic school problems_____

How is your child's behavior in school?

	Good	Average	Poor	N/A
Current Grade	_____	____	____	____
Previous Grade	_____	____	____	____
Pre-School/Daycare	_____	____	____	____

Does your child's current teacher describe any of the following as significant classroom problems?

Doesn't sit still in his/her seat	_____
Frequently gets up and walks around the classroom	_____
Shouts out and doesn't wait to be called upon	_____
Won't wait his/her turn	_____
Does not cooperate well in group activities	_____
Typically does better in one-to one relationship	_____
Doesn't respect the right of others	_____
Doesn't pay attention during classroom activities	_____
Any attendance problems since first grade?	_____

Describe briefly any classroom behavioral problems_____
_____

RELATIONSHIPS WITH OTHER CHILDREN

Does your child seek friendships with other children his/her own age? _____

Is your child sought by other children his/her own age? _____ Older_____ Younger_____

Describe briefly any problems your child may have with children his/her own age: _____
_____

Home Behavior

Check below those behaviors that you believe your child shows to a greater degree when compared With other children his/her own age:

Hyperactivity (High Activity Level) _____ **Poor Attention Span _____**
Impulsivity (Poor Self Control) _____ **Temper Outbursts _____**
Eating Problems_____ **Sleeping Problems _____**
Sudden Outbursts of Physical Abuse towards others_____
Unusual Worries or Fears_____ Describe_____

INTERESTS AND ACCOMPLISHMENTS

What are your child's main hobbies and interests? _____
_____
What does your child do best? _____
_____
What does your child dislike doing most? _____

MEDICAL HISTORY

If your child's medical history includes any of the following, please note the Age when the incident or illness occurred and any other pertinent information.

Major diseases (describe any complications) _____
_____

Operations _____

Hospitalizations _____

Head Injuries: _____with unconsciousness _____without unconsciousness

Convulsions: _____with fever _____ without fever

Other: _____Eye problems _____Ear Problems

_____Poisoning _____ Allergies

Medication Allergies: _____

Adverse Reaction to Medications: _____

Has child has all immunizations? Yes_____ No_____

PRESENET MEDICAL STATUS **Height_____ Weight_____**

Any medical condition for which child is being treated
_____

Medications child is taking on an ongoing basis
_____

Date of last physical examination_____ Date of last dental examination_____

Current Physician_____

Does anyone in the family currently have any contagious diseases? If so, please describe: _____
_____

Please note any nutritional problems: _____

SUBSTANCE ABUSE OR ALCOHOL PROBLEMS
Does the child use any alcohol or mood altering drug(s)? Y_____ N_____

YES OR NO	SUBSTANCE	AMOUNT	ROUTE(oral, inhaled, injected)	FREQUENCY	LAST USED
	Beer				
	Wine				
	Liquor				
	Cocaine				
	Hallucinogens				
	Amphetamines				
	Solvents				
	Narcotics				
	Marijuana, Hashish				

ANY MEDICAL CONSEQUENCES OF ALCOHOL/DRUG ABUSE?

	Blackouts		Shakes		DT'S		Hallucinogens		Other
	Hepatitis		Pancreatitis		Cirrhosis		Seizures		

HAS ALCOHOL OR DRUG ABUSE LED TO LEGAL PROBLEMS INCLUDING DUI?
Y_____ N_____
Describe_____
_____

HAS YOUR CHILD HADS ANY PREVIOUS TREATMENT FOR ALCOHOL OR DRUG ABUSE OR DEPENDENCE? Y_____ N_____

When? _____ Where? _____

HAS YOUR CHILD PREVIOUSLY ATTENDED AA, NA, OR CA MEETINGS? Y_____ N_____

When? _____

ANY FAMILY HISTORY OF ALCOHOL OR DRUG ABUSE? Y_____ N_____

Who? _____

NICOTINE USE PER DAY (Nicotine is in cigarettes, cigars, and tobacco chew):

_____

FAMILY MEDICAL DATA (Biological Mother)

Medical problems (specify):_____

Emotional Problems Y_____N_____**Describe**_____
Mental Retardation Y_____N_____**Describe**_____
Chronic Disease Y_____N_____**Describe**_____

Has any of your biological relatives (not including yourself) ever had problems similar to those you Have?
If so, describe_____
_____

FAMILY MEDICAL DATA (Biological Father)

Medical problems (specify) _____
Emotional Problems Y_____N_____**Describe**_____
Mental Retardation Y_____N_____**Describe**_____
Chronic Disease Y_____N_____**Describe**_____

Have any of your biological relatives (not including yourself) ever had problems similar to those you Have?
If so, describe_____
_____

Do referred child's brothers and sisters have any medical, social, emotional or academic problems?
Please describe_____
_____

Does your child have any legal charges or history with the legal system?
_____
_____
_____

List names and addresses of any other professionals consulted:
_____
_____
_____
_____

PREVIOUS COUNSELING, HOSPITALIZATIONS, SUBSTANCE ABUSE TREATMENT (INDIVIDUAL OR FAMILY):

Where **Dates**

_____ _____
_____ _____
_____ _____

Reason treatment ended: _____

Has your child had a psychiatric or psychological evaluation? _____

What do you hope your family will gain from treatment at this time? _____
_____
_____
_____

PLEASE SIGN AND DATE:

_____

Signature **Date**

_____
_____

AGENCY USE ONLY

Reviewed by: _____
Therapist's Signature