

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

<u>NAME</u>	<u>AGE</u>	<u>RELATION</u>

OUTSIDE THE HOME

<u>NAME</u>	<u>AGE</u>	<u>RELATION</u>

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 _____ Breech _____

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 _____ Was 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:

	<u>Good</u>	<u>Average</u>	<u>Poor</u>	<u>N/A</u>
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:

	<u>Good</u>	<u>Avg.</u>	<u>Poor</u>	<u>N/A</u>
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?

	<u>Good</u>	<u>Avg.</u>	<u>Poor</u>	<u>N/A</u>
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? _____

YES OR NO		AMOUNT	ROUTE (oral, inhaled Injected)	FREQUENCY	WHEN 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 HAD 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? _____

FAMILY MEDICAL DATA (Biological Mother)

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 _____

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