



# THE LAKEWOOD GROUP, LLC

*Mental Health Services*

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## INITIAL FAMILY HISTORY Children & Adolescents

PATIENT INFORMATION:

Date \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Place of birth \_\_\_\_\_

Age \_\_\_\_\_ Gender \_\_\_\_\_ Race (Optional) \_\_\_\_\_ Religion (Optional) \_\_\_\_\_

CHILD LIVES WITH \_\_\_\_\_ GRADE IN SCHOOL \_\_\_\_\_

SCHOOL \_\_\_\_\_ TEACHER (If in Elementary School) \_\_\_\_\_

Family Physician \_\_\_\_\_ Please list any other physicians who have treated you in the  
past 2 years \_\_\_\_\_

FATHER:

NAME \_\_\_\_\_ AGE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

MARRIAGES AND DIVORCES: NAMES & YEAR(S) \_\_\_\_\_

MOTHER:

NAME \_\_\_\_\_ AGE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

MARRIAGES AND DIVORCES: NAMES & YEAR(S) \_\_\_\_\_

STEP FATHER:

NAME \_\_\_\_\_ AGE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

MARRIAGES AND DIVORCES: NAMES & YEAR(S) \_\_\_\_\_

STEP MOTHER:

NAME \_\_\_\_\_ AGE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

MARRIAGES AND DIVORCES: NAMES & YEAR(S) \_\_\_\_\_

OTHER CHILDREN IN THE HOME:

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

RELATED CHILDREN NOT LIVING IN THE HOME:

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

OTHER MEMBERS OF THE HOUSEHOLD:

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_

AGE \_\_\_\_\_ GENDER \_\_\_\_\_ GRADE \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

CURRENT PROBLEMS:

Name of person completing this form \_\_\_\_\_ What concerns you about your child or adolescent? \_\_\_\_\_

How long have these problems existed? \_\_\_\_\_ What has been tried to solve the problems? \_\_\_\_\_

Previous evaluations or treatment by a psychologist, psychiatrist or counselor?  Yes  No, If yes:

Dates	Location	Therapist	Results

Has any medication been prescribed for these problems?  Yes  No If yes:

Medication	Strength	Number taken	Physician Prescribing	Results
		<input type="checkbox"/> /day <input type="checkbox"/> /wk		
		<input type="checkbox"/> /day <input type="checkbox"/> /wk		
		<input type="checkbox"/> /day <input type="checkbox"/> /wk		
		<input type="checkbox"/> /day <input type="checkbox"/> /wk		

What do you think might be causing the problem? \_\_\_\_\_

**MEDICAL HISTORY:**

Has your child or adolescent now or ever been under the care of a physician for any type of medical problem other than the reason for being here? If so, please explain:

Dates	Location	Physician	Problem and Treatment

Please list all **medications** your child or adolescent is currently taking:

Medication	For what	Strength	Number taken	Physician Prescribing	Results
			<input type="checkbox"/> /day <input type="checkbox"/> /wk		
			<input type="checkbox"/> /day <input type="checkbox"/> /wk		
			<input type="checkbox"/> /day <input type="checkbox"/> /wk		
			<input type="checkbox"/> /day <input type="checkbox"/> /wk		

Non-prescription medications \_\_\_\_\_

Please list all medications your child or adolescent is allergic to, including X-ray dye \_\_\_\_\_

Please list any and all **surgeries**:

Dates	Location	Physician	Problem and Treatment

Please list any **other hospitalizations**:

Dates	Location	Physician	Problem and Treatment

Approximate date of your child or adolescent's last checkup \_\_\_\_ - \_\_\_\_ - \_\_\_\_ For:  Illness  Routine  School

Results \_\_\_\_\_

Name of Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Included in checkup:  Physical  Blood tests  Urine tests  X-ray  EKG (cardiogram)  Pap smear

Date of last tetanus shot \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of most recent Tine Test \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Please give **inoculation dates**:

<u>DPT or TD:</u>	Basic series	Boosters
<u>Polio:</u>	Basic series	Boosters
<u>Measles:</u>	<u>Mumps:</u>	<u>Rubella:</u>

Has your child or adolescent ever had allergy testing?  Yes  No If yes, please give dates and results \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight one year ago \_\_\_\_\_ 10 lb. weight change in past year?  Yes  No

Number of cigarettes + cigars + pipefuls + dips \_\_\_\_\_ /day /wk. /mo. /yr. Age began using \_\_\_\_\_

Number of alcoholic drinks \_\_\_\_\_ /day /wk. /mo. /yr. Age began using \_\_\_\_\_ Last drunk \_\_\_\_\_

Has alcohol been used more heavily in the past?  Yes  No Have unprescribed drugs including "street" drugs

been taken?  Yes  No If yes, please specify \_\_\_\_\_

Number of caffeine drinks per day: \_\_\_\_\_ coffee \_\_\_\_\_ tea \_\_\_\_\_ colas \_\_\_\_\_ Mountain Dew \_\_\_\_\_ other

**FOR GIRLS:** (If you are uncomfortable answering any of these questions, you may respond later in private.)

Having periods?  Yes  No Date of last normal menstrual period \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age puberty onset \_\_\_\_\_

Menses:  Normal  Heavy  Irregular, Please Explain \_\_\_\_\_

\_\_\_\_\_ Possibility of current pregnancy?  Yes  No

Number of: Pregnancies \_\_\_\_\_ Miscarriages \_\_\_\_\_ Complications \_\_\_\_\_ Abortions \_\_\_\_\_

History of venereal diseases (herpes, gonorrhea, syphilis, etc.): \_\_\_\_\_

Date of last Pap smear \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth Control Pills \_\_\_\_\_

**FOR BOYS:** (If you are uncomfortable answering any of these questions, you may respond later in private.)

Age puberty onset \_\_\_\_\_ History of venereal disease (herpes, gonorrhea, syphilis, non-specific discharge, etc.): \_\_\_\_\_

**FOR BOYS AND GIRLS:** Please indicate if you have experienced any of the following:

CONDITION	YES	AGES	CONDITION	YES	AGES	CONDITION	YES	AGES
Fever in last week			Periods of unconscious			Bladder difficulty		
Frequent headaches			Seizures or convulsions			Bowel difficulty		
Recent change in hearing			Vision problems			Liver disease		
Recent change in vision			Frequent ear trouble			Tumors		
Numbness			Hearing impairment			Pneumonia		
Muscular weakness			Female disease/disorder			Fainting spells		
Dizziness			Heart disease			Kidney disease		
Seizures			Asthma			Rheumatic fever		
Tics			Allergies			Soft tissue inflammation		
Trouble breathing			Speech difficulty			Lymphangitis		
Chronic cough			Diabetes			Scabies		
Coughed up blood			P.M.S.			Serious accident		
Chest pains			Cancer			Surgery		
High Blood Pressure			Tuberculosis			Paralysis		
Abdominal pains			Memory difficulty			Shaking		
Change in bowel habits			Hypoglycemia			Ulcer		
Rectal bleeding			Scarlet fever			Insomnia		
Difficulty or pain in urination			Bursitis			Nervousness		
Blood in urine			Phlebitis			Depression		
Blackouts			Herpes Witlow			Alcohol use		
Trouble with walking or balance			Shortness of breath			Drug use		
Back Pain			Frequent diarrhea or constipation			Serious accident		
Other back problems			Frequent nausea or vomiting			Bedwetting		
Arthritis			High blood pressure			Soiling		
Frequent ear infections			Low blood pressure			Dropping objects		
Frequent sore throats			Meningitis			Menstrual difficulty		
Severe headaches			Weight gain			Thyroid difficulty		
Head injury			Weight loss			Balance difficulty		
Episodes of prolonged or high (>103) fever								

If any of the above were answered yes, please describe further. \_\_\_\_\_

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Check if anyone in your family has had:  Diabetes  Alcohol problems  Drug problems  Weight problems  Depression  Anxiety  Other psychological problems  Heart or blood pressure problems  Headaches

Please describe any family history (on natural mother's or natural father's side) of any of these problems \_\_\_\_\_

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<u>Family Medical History:</u>	<u>Age</u>	<u>Medical or Psychological Problems</u>	<u>Age Died</u>	<u>Year Died</u>	<u>Cause of Death</u>
Paternal Grandfather					
Paternal Grandmother					
Maternal Grandfather					
Maternal Grandmother					
Father					
Mother					
Brothers 1)					
2)					
3)					
4)					
Sisters 1)					
2)					
3)					
4)					
Children 1)					
2)					
3)					
4)					

**SCHOOL HISTORY:**

<u>GRADE</u>	<u>AGE</u>	<u>NAME OF SCHOOL</u>	<u>CITY, STATE</u>	<u>PASSED, RETAINED OR SOCIALLY PROMOTED</u>
Preschool				
Kindergarten				
1st				
2nd				
3rd				
4th				
5th				

<u>GRADE</u>	<u>AGE</u>	<u>NAME OF SCHOOL</u>	<u>CITY, STATE</u>	<u>PASSED, RETAINED OR SOCIALLY PROMOTED</u>
6th				
7th				
8th				
9th				
10th				
11th				
12th				

Describe any difficulties your child had adjusting to the first few weeks of school \_\_\_\_\_

Describe any difficulties your child had adjusting to the first year of school \_\_\_\_\_

**CURRENT SCHOOL PERFORMANCE:**

Please check current grades:

<u>SUBJECT</u>	<u>F (below 70)</u>	<u>C (70 - 79)</u>	<u>B (80 - 89)</u>	<u>A (90 - 100)</u>
Reading				
Writing				
Spelling				
Math				
Social Studies				
Science				
Foreign Language				
P. E.				

What school subjects have presented particular difficulty in the past? \_\_\_\_\_

Describe any recent changes in performance \_\_\_\_\_

Please describe any other academic problems \_\_\_\_\_

Please describe any other school problems \_\_\_\_\_

How have school problems been handled? \_\_\_\_\_  
\_\_\_\_\_

**SOCIAL:**

Please describe your child or adolescent's contacts with peers. Describe the amount of play with others, type of activities, group activities \_\_\_\_\_  
\_\_\_\_\_

What are your child or adolescent's favorite activities or hobbies? \_\_\_\_\_  
\_\_\_\_\_

Does your child or adolescent have a best friend?  Yes  No If yes, Age(s) \_\_\_\_\_ How long? \_\_\_\_\_

**PREGNANCY & BIRTH HISTORY:**

Was child  planned or  unplanned. How did mother feel about this pregnancy? \_\_\_\_\_

How did father feel? \_\_\_\_\_ Describe any emotional problem or stress during pregnancy \_\_\_\_\_

Was mother nervous, apprehensive or unusually moody during pregnancy?  Yes  No If yes, please describe \_\_\_\_\_

Were alcohol, drugs or medications used during pregnancy?  Yes  No If yes, please describe \_\_\_\_\_

Were there any physical problems during pregnancy?  Yes  No If yes, please describe \_\_\_\_\_

Was baby unusually active during pregnancy?  Yes  No Was pregnancy full term?  Yes  No If not, what was length of pregnancy? \_\_\_\_\_ Length of labor? \_\_\_\_\_ Was labor particularly difficult?  Yes  No

Was father present at delivery?  Yes  No Was delivery:  spontaneous  caesarean  instruments used

Was medication used during delivery?  Yes  No If yes:

MEDICATION	DOSE	MEDICATION	DOSE	MEDICATION	DOSE

Which part of baby was born first? \_\_\_\_\_ Was breathing spontaneous?  Yes  No Birth weight \_\_\_\_\_

Were there any birth complications?  Yes  No If yes, please describe \_\_\_\_\_

Were there any peculiarities in your child's appearance or behavior at birth or during infancy?  Yes  No If yes, please describe \_\_\_\_\_

**DEVELOPMENT:**

Was baby  breast fed  bottle fed  both? Describe any problem with nursing and/or formula \_\_\_\_\_



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At what age was baby completely weaned? \_\_\_\_\_ Who helped mother with the baby? \_\_\_\_\_

Describe amount of baby's activity (very active, restless, quiet, etc.). \_\_\_\_\_

Describe anything unusual or that caused strain (illness, disagreements, separation, etc.) in the family during the baby's first year \_\_\_\_\_

AT WHAT AGE DID YOUR CHILD: first smile? \_\_\_\_\_, first speak words? \_\_\_\_\_, first speak sentences? \_\_\_\_\_, first walk without support? \_\_\_\_\_, first show fear of strangers? \_\_\_\_\_, begin sleeping alone? \_\_\_\_\_, begin toilet training? \_\_\_\_\_, complete bowel training? \_\_\_\_\_, stop wetting self at night? \_\_\_\_\_, during the day? \_\_\_\_\_. Describe any toilet training difficulties \_\_\_\_\_

Did child ever have any difficulty speaking?  Yes  No If yes, at what age \_\_\_\_\_, please describe \_\_\_\_\_

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At what age did child show curiosity about sex? \_\_\_\_\_. Describe the nature of the question and how it was dealt with \_\_\_\_\_

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Has masturbation been known to occur?  Yes  No At what age? \_\_\_\_\_ How did parents react? \_\_\_\_\_

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How did child react to frustration and disappointment? \_\_\_\_\_

Did child have temper tantrums?  Yes  No At what age? \_\_\_\_\_ Please describe \_\_\_\_\_  
\_\_\_\_\_ What seemed to cause them? \_\_\_\_\_

Who usually disciplined child? \_\_\_\_\_ What methods were used? \_\_\_\_\_  
\_\_\_\_\_ What worked? \_\_\_\_\_

Did parents usually agree on discipline?  Yes  No If not, who won? \_\_\_\_\_

Did child have persistent fears (darkness, dogs, strangers, etc.)  Yes  No If yes, at what age(s) \_\_\_\_\_

Please describe \_\_\_\_\_

How were these handled? \_\_\_\_\_

Did child ever share a room?  Yes  No If yes, with whom? \_\_\_\_\_ At what age(s)? \_\_\_\_\_

Describe any eating problems \_\_\_\_\_ At what age(s)? \_\_\_\_\_

Describe any sleeping problems \_\_\_\_\_ At what age(s)? \_\_\_\_\_

Have any deaths occurred in the family since your child was born?  Yes  No If yes, please give dates and relationship to your child \_\_\_\_\_

Has your child ever lived away from the present family for more than a few days?  Yes  No If yes, please give details and dates \_\_\_\_\_

Thank you for taking the time to complete this extensive questionnaire!



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## No Child Custody Testimony Agreement

I, \_\_\_\_\_, the parent, guardian or personal representative of the minor child, \_\_\_\_\_, agree not to call to court, subpoena or otherwise engage the treating mental health professional (therapist, provider), \_\_\_\_\_ in any legal proceedings regarding child custody. I also agree to instruct any counsel representing me in any issue regarding child custody not to call to court, subpoena or otherwise engage the treating mental health professional in any legal proceedings regarding child custody.

I understand that the purpose of the treatment of my child is to address concerns of mental and/or behavioral health. I understand in the case of divorce, separation or other estrangement between the parents or even between parent and child, that it is important for my child to have a therapeutic sanctuary where feelings and thoughts can be expressed without concern about either parent's reaction to such expressions. I further understand that the confidential nature of such communication between my child and his or her therapist is an important part of his or her therapy, allowing a freer expression of thought and feeling. I understand the importance of the trust my child establishes in the therapist and in the process. I understand that the involvement of the mental health professional in court would break this trust, forcing the exposure of private thoughts and feelings into a public record against the will of my child and the therapist. I further understand that forcing testimony would not be in the best interest of my child and would be likely to undermine future psychotherapy or counseling/testing that may be necessary in the future.

I understand that there are several forensic psychologists available in the area and that these psychologists may be engaged to provide an independent evaluation for court purposes. The Lakewood Group will provide the names of forensic psychologists if requested.

\_\_\_\_\_  
Parent, guardian or personal representative Date

\_\_\_\_\_  
Parent, guardian or personal representative Date