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_____________________________________ NAME_____________________________________

AGE ______ GENDER__________ GRADE ______ AGE ______ GENDER________ GRADE_____

RELATIONSHIP_________________________________ RELATIONSHIP_____________________________

NAME____ NAME_____________________________________

AGE ______ GENDER________ GRADE ______ AGE ______ GENDER___________ GRADE_____

RELATIONSHIP________________________________ RELATIONSHIP_____________________________

RELATED CHILDREN NOT LIVING IN THE HOME:

NAME_____________________________________ NAME_____________________________________

AGE ______ GENDER___________ GRADE ______ AGE ______ GENDER____________ GRADE_____

RELATIONSHIP_________________________________ RELATIONSHIP_____________________________

NAME____ NAME_____________________________________

AGE ______ GENDER___________ GRADE ______ AGE ______ GENDER____________ GRADE_____

RELATIONSHIP________________________________ RELATIONSHIP_____________________________

OTHER MEMBERS OF THE HOUSEHOLD:

NAME_____________________________________ NAME_____________________________________

AGE ______ GENDER_______ GRADE ______ AGE ______ GENDER____________ GRADE_____

RELATIONSHIP________________________________ 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
		☐/day		
		☐/day		
		☐/day		
		☐/day		

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
			☐/day		
			☐/day		
			☐/day		
			☐/day		

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:**

DPT or TD:	Basic series	Boosters
Polio:	Basic series	Boosters
Measles:	Mumps:	Rubella:

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.____

____

____

____

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________

____

____

____

Family Medical History:	Age	Medical or Psychological Problems	Age Died	Year Died	Cause of Death
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:

GRADE	AGE	NAME OF SCHOOL	CITY, STATE	PASSED, RETAINED OR SOCIALLY PROMOTED

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

SUBJECT	F (below 70)	C (70 - 79)	B (80 - 89)	A (90 - 100)
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______________

____

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 _________

____

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

____

Has masturbation been known to occur? ☐ Yes ☐ No At what age? ______ How did parents react? _________

____

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