



FAULKNER UNIVERSITY

CENTER FOR THERAPY AND RESEARCH

Mental Health Therapy Pediatric Case History

Please complete the form to the best of your ability and return it prior to your evaluation appointment.
We will review this form with you and help you complete it during our visit with your child.

Legal Name: _____

Today's Date:

Age: _____ Birthdate: _____ Sex: Male Female

Mother's (or guardian's) Name _____

Phone# _____

Father's (or guardian's) Name _____

Phone# _____

Home Address _____

Who has custody of this child? _____

Who is filling out this questionnaire? Relationship to child?

Please describe any health information that may be important for the therapist to know (medications, major illness, medical diagnoses, etc.). Please include the name of your child's current physician.

Is your child currently taking any medication? Yes No

If yes, please list.

PRESENTING PROBLEM:

What are your top 3 concerns/reasons for seeking therapy for your child?

What effect have they had on your child's day-to-day life?

Has your child ever been treated for mental health problems in the past? If so, how old were they? Please include the name of the therapist if possible.

Please circle all symptoms that you have noticed recently in your child. Choose the severity as you feel best describes each one.

(0) Not Present (1) Mild (2) Moderate (3) Severe

Depression 0 1 2 3	Memory Problems 0 1 2 3	Hyperactivity 0 1 2 3
Anxiety 0 1 2 3	Loss of Interest 0 1 2 3	Obsessive Thoughts 0 1 2 3
Mood Swings 0 1 2 3	Irritability 0 1 2 3	Low Self Esteem 0 1 2 3
Appetite Changes 0 1 2 3	Excessive Worry 0 1 2 3	Anger Problems 0 1 2 3
Sleep Changes 0 1 2 3	Suicidal Ideation 0 1 2 3	Self - Injury 0 1 2 3
Confusion 0 1 2 3	Low Energy 0 1 2 3	Aggressive Behavior 0 1 2 3
Relationship Issues 0 1 2 3	Poor Self Control 0 1 2 3	Defiance 0 1 2 3
Difficulty Concentrating 0 1 2 3		

FAMILY INFORMATION

Father's occupation _____ Employer _____

Mother's occupation _____ Employer _____

Siblings: Names & Ages:

Is there anyone else living in the home? If yes, please list.

Are there any family or social stressors that could be affecting the child? (For example: divorce, death, military, relocation) Yes No

If yes, please describe:

EDUCATION/ SOCIAL INFORMATION

What school does your child attend, and in what grade?

Does your child have any learning or behavioral issues in school? Yes No

If yes, please describe.

Does your child regularly engage in social activities? Yes No

If yes, please describe.

How would you describe your child's personality in a couple of sentences?

How does your child typically respond when redirected?

ADDITIONAL INFORMATION

Who does your child have in their life that provides additional support to them, especially those they have regular access to? (grandparents, extended family, friends, coaches, teachers, etc.)

Please tell us some of your child's strengths. What are the best things about him/ her?

What are his/ her favorite things to do for fun?

Is there anything else you would like us to know about your child?
