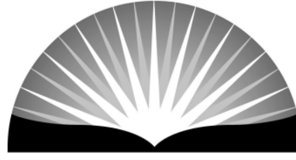
Michael S. Trieger, Psy.D.
Licensed Clinical Psychologist

Melissa Fisher Paoni, Ph.D.
Licensed Clinical Psychologist

Helen P. Appleton, Ph.D., ABPP
Licensed Clinical Psychologist

Mary L. Ossowski, LCSW
Licensed Clinical Social Worker



Springfield Psychological Center, LLC

Lori K. McKenzie, Psy.D.
Licensed Clinical Psychologist

Donald R. Henke, LCSW
Licensed Clinical Social Worker

Bill McKenzie, MA, LCPC
Licensed Clinical Professional Counselor

Jenna Reid Yates, Ph.D.

CONFIDENTIAL HISTORICAL DATA RECORD
CHILD APPLICATION

Child's Name:____Nickname:_____________Date of Birth:__/__/____

Date of Application: ___/___/___ Age:______ Gender:__Male__Female

Parent/Guardian:____Address:____________________________________

Home Phone:______________________________________Work Phone_____________________________________

School:_____________________________________Grade:_____Phone:___________Principal____________________

Teacher: ____________________________Special Ed.: __________________Counselor:________________________

List previous schools attended with dates: ____

Foster care:______________________________________Adopted:____________________Age Adopted:____________

Referred by: ____Reason:_____________________________________

Family Physician or Medical Group: _____________________________Address: _________________________________

Phone: _________________________Fax: ________________________Nurse: ___________________________________

Are there problems in the family that may relate to the child's problem? YES….NO

If yes, specify:____

Any history of mental, emotional or neurological illness such as depression, anxiety, hyperactivity, learning disability or drug/alcohol problems in either parent's family? Please indicate whom, what type of problem and with what result:

____

____

If parents are not living together, please describe amount and frequency of contact with each parent.

____

BIRTH & DEVELOPMENT

Was the pregnancy or birth complicated? If yes, please describe:

____

____

Any problems during the first year (i.e. colic, feeding problems, sleep problems)?

____

____

Age for milestones: Sat by self_______ Walked alone______ Said first word ______ Spoke in sentences________

Toilet Trained: Urine day ______Urine night _______Bowel day _______ Bowel night_______

To whom was the child most attached during his/her infancy? ____

What events in raising your child stand out as unusual or distinguished him/her from other children?

____

MEDICAL HISTORY

Any significant events in the child's medical history (i.e. illnesses, injuries, surgeries):

Other health problems: ____

How is your child's vision/hearing? __________________ Medications? ____

Has your child ever been physically or sexually abused? _____________ When? ________________________________

Child's current academic achievement is (circle one):
*Below Average *Average *Above Average*Don't Know

Child's intellectual ability is (circle one):
*Below Average *Average *Above Average*Don't Know

Psychologist____ Phone: ____________________

Social Worker: ____Phone: ____________________

Probation Officer: ____Phone: ____________________

List all persons now living in the household and then list others who have lived there during the child's lifetime.

Name	Relationship to child	Age	Occupation

1. ____

2. ____

3. ____

4. ____

Any other marriages for either parent? ________________________________Dates: _____________________________

Attitude of sibling(s) towards the child: ____
____

Symptom Checklist (Please check all that apply):

1. __ Attention problems
2. __ Concentration problems
3. __ Does not listen
4. __ Fails to finish tasks
5. __ Often loses things
6. __ Easily distracted
7. __ Forgetful
8. __ Fidgets or squirms
9. __ Runs excessively
10. __ Cannot play quietly
11. __ Talks excessively
12. __ Blurts out answers
13. __ Difficulty waiting turn
14. __ Depressed/discouraged
15. __ Eating disturbances
16. __ Sleep disturbance
17. __ Low energy
18. __Social Withdrawl
19. __ Suicidal thoughts/threats
20. __ Anxiety/panic
21. __ Fear of Dying
22. __ Fears/phobias
23. __ School stress
24. __ Overly clean
25. __ Physical complaints
26. __ Fights/temper display
27. __ Steals
28. __ Alcohol/drug use
29. __ Lies/boastful
30. __ Selfish
31. __ Disobedient/defiant
32. __ Cruel to animals
33. __ Truant from school/home
34. __ Learning problems
35. __ Messy
36. __ Tics
37. __ Dislikes school
38. __ Wets the bed at night
39. __ Daytime wetting
40. __ Bowel accidents
41. __ Sexual misbehavior
42. __ Fails to adjust with other children.
43. __ Unusual mannerisms
44. __ Prefers younger children
45. __Anger control problems
46. __Cruel to others

Please describe above checked items:____

____

Describe what your child likes to do for fun:____

____

____

What situations, relationships, or events tend to be most difficult or upsetting for your child: _________________________

____

List your child's talents and skills: ____

____

____

We appreciate the effort which you have given to filling out this questionnaire. Your answers help to evaluate your child in a more efficient manner. Please add any additional comments which might be helpful______________________________

____

____

Signature____ Relationship______________________