



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 _____ Male, Female 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 _____ Male Female GRADE _____

AGE _____ Male Female GRADE _____

RELATIONSHIP _____

RELATIONSHIP _____

NAME _____

NAME _____

AGE _____ Male Female GRADE _____

AGE _____ Male Female GRADE _____

RELATIONSHIP _____

RELATIONSHIP _____

RELATED CHILDREN NOT LIVING IN THE HOME:

NAME _____

NAME _____

AGE _____ Male Female GRADE _____

AGE _____ Male Female GRADE _____

RELATIONSHIP _____

RELATIONSHIP _____

NAME _____

NAME _____

AGE _____ Male Female GRADE _____

AGE _____ Male Female GRADE _____

RELATIONSHIP _____

RELATIONSHIP _____

OTHER MEMBERS OF THE HOUSEHOLD:

NAME _____

NAME _____

AGE _____ Male Female GRADE _____

AGE _____ Male Female 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
		<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. _____

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 _____

<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				
6th				

<u>GRADE</u>	<u>AGE</u>	<u>NAME OF SCHOOL</u>	<u>CITY, STATE</u>	<u>PASSED, RETAINED OR SOCIALLY PROMOTED</u>
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_____

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 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!