Jessica L. Cardwell, Psy.D., LLC

Licensed Clinical Psychologist
503 Carlisle Dr., Suite 225-E
Herndon, VA 20170
(571) 335-0893

Child Client Background Form

Child's Name:_____ Preferred Name:_____

Today's Date:_____ Person Completing Form:_____

What are your primary concerns regarding your child/specific questions you would like help with?

_____
_____
_____
_____
_____

When did you first become concerned about your child?_____
_____

Early Developmental History:

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Is this child your biological child or adopted (circle)? Biological Adopted

If adopted, at what age did you adopt this child?_____

If adopted, please list country of birth for this child:_____

Did the pregnancy have any complications (circle)? No Yes (explain):_____
_____

How long was the pregnancy?_____ Baby's birth weight:_____

Were there any difficulties for this child during the first year (circle)? No Yes (explain): _____
_____
_____

Please list the age at which your child reached the following milestones, were there any notable delays:

Said first word: _____
Used simple sentences: _____
Sat up alone: _____
Crawled: _____
Walked alone: _____
Toilet trained during day: _____
Dry at night: _____

Social/Behavioral Concerns:

Do you have any concerns about alcohol/drug use (circle)? No Yes (explain):_____
_____
_____

Have there been any legal problems (circle)? No Yes (explain):_____
_____
_____

Are you concerned about sexual activity? No Yes (explain):_____
_____
_____

Family Information:

Please list who has legal guardianship of this child: _____

Please circle parents' marital status: Never Married Married Separated Divorced Widowed

If parents are separated, divorced, widowed, please explain when this occurred:_____
_____

If parents are separated or divorced, please describe the custody arrangement:_____
_____

If one of the parents is NOT living in the child's primary home, please explain the frequency of contact:
_____
_____

Please list all persons living in the child's primary home:

Name	Relationship to Child	Age	M/F

If any immediate family member (e.g, parent or sibling) is living elsewhere, please list:

Name	Relationship to Child	Age	M/F

Medical History:

Please list the names and doses of any prescription medications your child currently takes:

_____

_____

_____

Please list the names and doses of any non-prescription/over-the-counter medications your child currently takes: _____

_____

Does your child have a history of any of the following? If Yes, please explain:

Allergies	No	Yes:_____
Hearing Problem	No	Yes:_____
Vision Problem	No	Yes:_____
Hospitalization	No	Yes:_____
Serious Accident	No	Yes:_____
Serious Illness	No	Yes:_____
Chronic Illness	No	Yes:_____
Seizure	No	Yes:_____
Tics	No	Yes:_____

Are any of the following current concerns for your child? If Yes, please explain:

Eating problems	No	Yes:_____
Sleep problems	No	Yes:_____
Stomachaches	No	Yes:_____
Headaches	No	Yes:_____
Menstrual Cycle	No	Yes:_____

Please circle Yes/No for any of the services your child is receiving or did receive in the past:

Speech/language therapy	No	Yes:_____
Occupational Therapy	No	Yes:_____
Physical Therapy	No	Yes:_____
Counseling	No	Yes:_____
Educational Tutoring	No	Yes:_____

Educational History:

Name of current school:_____ Grade:_____

Does your child have and IEP or 504 Plan (circle)? YES NO

If your child has and IEP or 504 Plan, what services are provided?_____

_____

What grades or GPA does your child currently have? _____

Has your child ever repeated a grade (circle)? No Yes (what grade):_____

Please list all schools your child attended; list for what grades is she/he attended more than one school. If you homeschooled your child for any of these years, please note that as well.

Preschool:_____
Elementary:_____
Middle:_____
Junior High:_____
Highschool:_____

Has your child had any testing through the school (circle)? No Yes (when): _____

Is homework completion an area of concern (circle)? No Yes (explain):_____
_____

Has the school contacted you about behavioral concerns (circle)? No Yes (explain):_____
_____

Social History:

List all extracurricular activities (sports, clubs, etc.) that your child has been involved in over the past year:_____
_____
_____

List the activities/toys your child enjoys during free time:_____
_____
_____

Does your child entertain himself/herself well (circle): No Yes

Do you have concerns about your child's social development? No Yes (explain):_____
_____
_____

How does your child get along with siblings and parents?_____
_____
_____

How does your child get along with other children his/her age?_____
_____
_____

What do you think about your child's close friends/peer group?_____
_____
_____

Please circle yes/no for any of the following in the last year, and explain if yes:

Family Move No Yes:_____
Marital Problems No Yes:_____
Serious parent illness No Yes:_____
Serious sibling illness No Yes:_____
Serious accident to family member No Yes:_____
Parent job difficulties No Yes:_____
Death of friend/relative No Yes:_____

Please circle yes/no for a family history of the following. If yes, list who had these issues:

Learning difficulties No Yes:_____
ADHD/ADD No Yes:_____
Anxiety problems No Yes:_____
Autism No Yes:_____
Depression No Yes:_____
Bipolar Disorder No Yes:_____
Suicide attempt No Yes:_____
Drug/alcohol problem No Yes:_____
"Nervous Breakdown" No Yes:_____
Schizophrenia No Yes:_____
Any genetic syndrome No Yes:_____
Seizure disorder No Yes:_____
Thyroid problems No Yes:_____
Diabetes No Yes:_____

If there is any other information that you think will be helpful, please explain below:

_____
_____
_____
_____

I certify that, to the best of my knowledge, the information provided above is accurate.

_____ _____
Parent/Guardian Signature Date