PEDIATRIC PSYCHOLOGY ASSOCIATES

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FORENSIC FAMILY HISTORY FORM

Name of Parent/Caregiver Completing Form:_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

Child's Name_____Age_____Birthdate_____

(If more than 4 children please write on back of paper-child's name, age, birthdate)

Do your children have a cellular phone? If so, please list child's name and number(s)_____

_____

What are the concerns or difficulties that cause you to seek professional help at this time?

_____

_____

_____

Parent 1 Name_____Age_____ Birthdate_____

Email:_____Occupation:_____ Education_____

Cellular_____Alternative Phone:_____

Home Address_____

City_____ State_____ Zip Code_____

Attorney's name (if applicable) _____

Parent 2 Name_____Age_____ Birthdate_____

Email:_____Occupation:_____ Education_____

Cellular_____Alternative Phone:_____

Home Address (if different than Parent 1 Address)_____

City_____ State_____ Zip Code_____

Attorney's name (if applicable) _____

Date of: Marriage _____ Separation_____ Divorce_____ Check if Never Married _____

Are there other persons in the home(s)? _____If yes, who?_____

_____

If applicable, relationship with parent's significant other or step-parent?_____

Is there a parenting plan in place at this time? Yes ____ No ____ (If yes, please provide a copy)

Has a Guardian ad Litem been appointed: Yes_____ No _____

If yes, Name _____ Contact information _____

Is/are child(ren) living with biological or adoptive parents (circle one)?

If parents are living apart (separated or divorced) is the other parent aware that you are seeking psychological services?* Yes ___ No ___ **A consent from must be signed by the other parent if parents are divorced or living apart AND if the children will be part of our psychological sessions.*

If child(ren) is/are not living with both biological/adoptive parents, describe living/time-sharing arrangements:_____

_____

_____

How often do you have contact with the children when they are not with you? _____

_____

Describe the contact (visits, supervised/unsupervised, phone, etc): _____

_____

_____

How would you describe your relationship with the other parent?

Excellent _____ Good _____ Fair _____ Poor _____ Could not be worse _____

What effect do you think this relationship has on the children?

A great deal _____ Some _____ A little _____ None at all _____ Not sure_____

How often do you have contact with the other parent? _____

How do you communicate (text, Talking Parents, Our Family Wizard, email)?_____

_____

Describe the problem(s) that have occurred between you and the other parent:

_____

_____

_____

Are you fearful of the other party for any reason? _____

_____

Has the other party ever threatened to hurt you in any way? _____

_____

Has the other party every hit you or used any other type of physical force towards you? _____

_____

Has the other party emotionally sexually or emotionally abused you?_____

_____

Have you ever called the police, requested a protection for abuse order, or sought help for yourself as a result of abuse by the other party? _____

_____

Has the other party ever threatened to deny you access to your child(ren)?_____

_____

Do you have any concerns about the children's emotional or physical safety with you or the other party?_____

_____

Have you or the other party abused alcohol or drugs?_____

_____

Present use of alcohol (including beer, wine, liquor)

Daily _____ Once or twice a week _____ Once or twice a month _____ None _____

Current or prior use or abuse of drugs? (Please check all that apply)

Current _____Past _____ Neither _____ If yes, please list type used:_____

Please list use of prescription and/or non-prescription drugs:_____

_____

Have you ever been arrested for an alcohol/drug related crime? _____ If yes, please explain:

_____

_____

Have you ever undergone treatment for substance or alcohol use/abuse? _____ If yes, please explain: _____

_____

Please rate the effectiveness of this treatment: Very effective ____ Helpful ____ Waste of time ____

Do you have concerns regarding the other parent's use of alcohol or other substances? If yes, please explain:_____

_____

Are you now or have you ever been on probation or parole? _____ If yes, please explain:

_____

_____

Have you ever had a restraining order filed against you? _____ If yes, please explain:

_____

_____

Is there a restraining order in effect right now that you are involved in? _____

Have you or the other parent participated in domestic violence classes, batterer's intervention or anger management? Yes _____ No _____If so, when? _____

If yes, please rate the effectiveness of these classes in eliminating abusive behavior:

Very effective _____ Helpful _____ Waste of time _____

Have there ever been charges filed against you for physical assault, battery, domestic violence, or stalking? _____ If yes, please explain: _____

_____

Do you have any concerns about your physical safety during joint meetings held with the other parent? _____ If yes, please describe:_____

_____

_____

Is there anything else that would be helpful for me to know about the other parent, your child, or your situation? _____

_____

_____

BRIEF FAMILY HISTORY

Are there any health/learning/emotional issues about your child(ren) I should be made aware of?

If so, please list child's name and describe in detail:_____

_____

_____

_____

_____

What language(s) does your child(ren) speak and which is primary?_____

What language(s) are spoken in the home and which is primary?_____

Religious Affiliation:_____

Where does your child(ren) sleep in their home(s)? _____

By whom is your child(ren) usually disciplined?_____

What type of discipline is used?_____

Usually for what reason?_____

How does your child(ren) respond to discipline?_____

Do parents differ on discipline? No_____ Yes_____ If so, how?_____

_____

_____

Please mark any areas which constitute a problem for your child(ren)-check and list name of child:

Eating_____Sleeping_____ Nightmares_____Thumb sucking _____Nail biting_____

Bedwetting_____ Wetting in clothing _____Soiling in bed_____ Soiling in clothing_____

Getting along with friends_____Self-help skills (dressing, bathing, etc.)_____

List school and grade level of your child(ren):

_____

_____

Has your child(ren) ever had counseling/psychotherapy, psychoeducational or psychological testing, speech, occupational or physical therapy, or seen a psychiatrist or received medication for behavior, attention or emotional problems ? _____ If yes, list child(ren) name, date(s), name of practice/therapist(s) for each area:_____

_____

_____

Is there any family member (sibling, parent, grandparent, cousin, etc.) who presently or in the past have (or had) learning, attentional, or psychological/emotional issues or were in special classes? If yes, who and what kind/type?_____

In addition to the current family situation/conflict, has your child(ren) ever experienced any traumatic events (e.g., death of a close relative or friend, accident, etc.)?_____If yes, please list child's name and describe_____

_____

_____

Please put any other comments that will help me understand your child(ren) and current family situation better_____

_____

_____

What are your goals/expectations from treatment?_____

_____

_____

What do you think it would take to achieve your treatment goals? _____

_____

_____

_____

Please note <u>we do not confirm appointments</u>, although we typically provide courtesy appointment reminders through email and text message. Even in the event that you do not receive a courtesy reminder, you are still responsible for your appointment. Please list your email and best cellular contact number below if you would like a courtesy reminder.

Email address (please write clearly):_____

Cellular number:_____

How were you referred to our office?_____

Phone and/or email of referral source?_____

Is it okay to contact and thank the party responsible for the referral? ☐ Yes ☐ No

Signature _____

CONSENT FOR TREATMENT

I voluntarily agree to and give consent for treatment by Pediatric Psychology Associates for myself and/or my family members.

Signature_____ **Date**_____

Printed Name_____ **Relation to child**_____