Ben C. Ghozali, Psy.D., P.A.

Licensed Psychologist

Child/Adolescent History Form

Date:_____

Child's Name:_____ Age:_____ DOB:_____
School:_____ Grade:_____

Parents:	Name	Age	Education	Occupation
Mother				
Father				
Stepmother				
Stepfather				

Marital Status: Married_____ Separated____ Widowed____ Other_____
Date married_____ Date Separated/Divorced_____ Date remarried_____

Other Family Members:

Name	Age	Relationship

Who is the child's pediatrician?_____
Current medical/physical problems:_____
_____

Is your child being treated by a psychiatrist? If so, who?_____

Please list any medications that your child is taking:	Dosage:	What for:

Does your child report or do you notice any side effects?_____
_____

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What are your primary concerns about your child?_____

Is your child aware of the problems and/or concerns? Is your child worried?_____

What questions would you like to have answered?_____

Describe your goals for treatment with your child:_____

Has anything happened that may have caused and/or contributed to the emotional/behavioral problems that your child is experiencing?_____

Are there any legal issues currently affecting your child (e.g. divorce, custody, criminal activities, etc.)?_____

Signature:_____
Relationship to child:_____