Andy McGarrahan, Ph.D.
12820 Hillcrest Road, Ste. 217
Dallas, TX 75230
972-726-9100
Fax 972-726-9101

History Form

Child's Name: ______________________ Age: ________ Today's Date: __/__/__

Address: ______________________ How long at this address? __________

City: __________ State: __________ Zip/Postal Code: __________

Child's Sex: __________ Child's Birthplace: __________ Birthdate: ____/____/____

Who referred you to Dr. McGarrahan?

Name: __________ Address / phone : ______________________

Father's Name: __________ Age: _____ Employer: __________

Work Phone: __________ Can I contact you at this number? Y N Leave a message? Y N

Home Phone: __________ Can I contact you at this number? Y N Leave a message? Y N

Cell Phone: __________ Can I contact you at this number? Y N Leave a message? Y N

E-mail address: ______________________ Type of Work: __________

Mother's Name: __________ Age: _____ Employer: __________

Work Phone: __________ Can I contact you at this number? Y N Leave a message? Y N

Home Phone: __________ Can I contact you at this number? Y N Leave a message? Y N

Cell Phone: __________ Can I contact you at this number? Y N Leave a message? Y N

E-mail address: ______________________ Type of Work: __________

Please describe the problems for which help is needed at this time.

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Has this child ever received mental health treatment (including psychotherapy or prescribed psychiatric medication)? No Yes

If yes, please complete the following history of psychiatric/psychological treatment (including psychiatric medication prescribed by a non-psychiatrist physician such as a pediatrician).

Name of Organization/Professional	Date	Address

Current Family Stressors: Please include things such as recent death in family, caregiver relationship problems, financial problems, serious medical or psychiatric illness, job problems or unemployment, domestic violence…

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Trauma: Please include any traumas impacting this child such as witnessing domestic or other violence, sexual, physical or emotional abuse of this child, neglect, or accidents where this child or someone was badly hurt…

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Has this child has ever experienced sexual, physical or emotional abuse? Yes No Not applicable

Has Child Protective Services ever been contacted or investigated a claim? Yes No Not applicable

If yes, is there currently an open case with Child Protective Services involving this child? Yes No

Psychiatric Medication History:
If this child has taken psychiatric medications, please list them below in chronological order:

Drug Name	Dose	Prescribed by	Dates Taken	Benefits	Side Effects

Therapy History:

Has this child ever received mental health related therapy? No Yes Don't know

If so, please complete the following information:

Type of Therapy	Provider	Why?	Dates	Frequency	Was it helpful?

With whom does the child live? ______________________________

Other Children (living with this child):

Name: ____________________ Age: _____ Relationship: ________________
Name: ____________________ Age: _____ Relationship: ________________
Name: ____________________ Age: _____ Relationship: ________________
Name: ____________________ Age: _____ Relationship: ________________

Other relatives or persons living in the home: ______________________________

Is this child adopted? No Yes

If yes, please describe the circumstance of the adoption:

____

____

School Information:

Name of School: ___________________________
Address of School: ___________________________
Current Grade (1st, 2nd, 11th…) ________________
List Previous Schools and dates attended:

___________________________________ __________ - __________
___________________________________ __________ - __________
___________________________________ __________ - __________

Grades repeated: _______ Grades skipped: ________

Expelled? No Yes If yes, # of times? ___________

Any known learning disabilities? No Yes If yes, please explain:

____
____

How does the school describe this child's current behavior?

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____
____

What does this child do best in at school?

____
____

Which of the following problems, if any, does this child have in school?

Does not do homework   Starts but does not finish homework   Fails to check homework

Poor handwriting   Poor spelling   Poor Math skills

Poor reading skills	Forgets assignments	Messy and disorganized
Does not remain seated	Incomplete classroom work	Poor attention in class
Non-compliant in class	Talks out inappropriately in class	Distracted
Test anxiety	Excessive time to complete assignments	
Makes many careless errors	Problems with written language	

Which of the following, if any, describe(s) this child's interactions with peers?

No friends	Few friends	Loses friends
Mean aggressive	Too shy or too timid	Trouble making new friends
Bossy, controlling	Risky behaviors	

Please provide any additional comments on homework, academic functions, and peer relations:

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What are your child's strengths?

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What does your child enjoy? What does your child enjoy doing in their free time?

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Family Medical History:

Do medical illnesses run in the family? (examples: seizures, thyroid problems, allergies) No Yes
If yes, please describe:

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Pregnancy and Birth History:

Were there any problems or abnormalities during pregnancy or birth of this child? No Yes

If yes, please describe:

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Developmental History:

Motor Development (Sitting, Crawling, Walking)	Normal	Fast	Slow	Don't know
Speech and Language	Normal	Fast	Slow	Don't know
Self-help Skills	Average	Fast	Slow	Don't know

Temperament (Infancy, Toddler, Preschool): Check any that apply

Shy or timid	Fearful	Impulsive	Rocking
Stubborn	Cautious	Poor sleep	Head banging
Affectionate	Underachiever	Curious	Into everything
Temper Outbursts	Overactive	Happy	Aggressive
Easy to manage	Slow to warm up	Poor eating	
Dare-devil	Wanted to be left alone	More interested in things than people	
Blank spells	Falling spells	Tore up toys more than usual	

Bowel Trained:	Average	Early	Late	Don't know
Bladder Trained:	Average	Early	Late	Don't know
Eating Behavior as a child:		Picky	Eats too much	

Family Psychiatric History:

(Please note any that apply: Major Depression, Bipolar Disorder, Anxiety Disorders, Schizophrenia, Tic Disorders, Substance/Alcohol Abuse, Suicide Attempts, Eating Disorders, or other Psychiatric problems)

If any of this child's **biological relatives** have had psychiatric problems, please specify the problem next to the relative.

Mother ______________________________

Father ______________________________

Brother ______________________________

Sister ______________________________

Grandmother ______________________________

Grandfather ______________________________

Aunt ______________________________

Uncle ______________________________

Outside of biological relatives, are there any **other people with whom the child has significant contact** who have psychiatric problems? No Yes Don't know

If yes, please specify the contact(s) and describe the problem(s), including treatment: ______________________
____
____
____

Medical History of Child:
Please describe any medical problems that this child has previously had or is currently experiencing:
____
____
____
____

Does this child currently take any medications for a medical illness? No Yes
If yes, please describe: ____
____

______________________________ ____________________
Signature of person completing form **Date**

______________________________ ____________________
Signature of person completing form **Date**