



# McCray Psychological Services, Inc.

## Client History Form

**(Complete and email back ASAP by choosing "SUBMIT" at end of this form)**

Phone (530) 318-2131 Fax (866) 899-6977 Lic. # PSY 17068 jamesmccray@earthlink.net

- Please help us get to know your child by completing this entire form **THEN SELECT THE "SUBMIT" BUTTON AT THE END OF THIS FORM.**
- Please **DO NOT SKIP QUESTIONS.** When possible, put "NA" if a question does not apply, if you cannot recall write "DK" (don't know), and if unsure of what the question means place a "?"
- Please do not try to type out long/complicated issues on this form, as they will be discussed during the interview.

This form was completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Client/Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Historical Facts:

<i>Family members living within the home</i>	Relationship: _____ Age: _____ Within the home: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Relationship: _____ Age: _____ Within the home: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Relationship: _____ Age: _____ Within the home: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Relationship: _____ Age: _____ Within the home: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	Relationship: _____ Age: _____ Within the home: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
<i>Language within home</i>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
<i>Has the family moved in the client's lifetime?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes, client's age at time of move: _____ Adjusted: <input type="checkbox"/> Well overall <input type="checkbox"/> Great difficulties <input type="checkbox"/> Other

### Birth:

<i>How old was the mother at the age of the client's birth?</i>	_____ years old.
<i>Prenatal care received.</i>	<input type="checkbox"/> Yes within the first trimester. <input type="checkbox"/> No, not until _____ weeks' gestation. <input type="checkbox"/> No, never received.
<i>Exposure to illegal or toxic substances while pregnant. i.e. cigarettes, alcohol, chemicals at work, etc.</i>	<input type="checkbox"/> None. <input type="checkbox"/> Yes. Please list type and extent of use: _____ _____
<i>Difficulties with pregnancy (not delivery)</i>	<input type="checkbox"/> None. <input type="checkbox"/> Yes.
<i>Amniocentesis (amniotic fluid removed by needle)</i>	<input type="checkbox"/> Completed with normal results <input type="checkbox"/> Not completed (Not a typical test for people <35 years old)
<i>Gestation</i>	Child was born at _____ weeks gestation (40 weeks is typical).
<i>Delivery</i>	<input type="checkbox"/> Vaginally. <input type="checkbox"/> Cesarean section.

<i>Complications</i>	<input type="checkbox"/> No significant difficulties. <input type="checkbox"/> Difficulties included: _____
<i>Birth weight and length</i>	_____ pounds- _____ ounces and _____ inches long.
<i>APGAR scores (if known)</i>	_____ at one minute and _____ at five minutes. <input type="checkbox"/> Unknown (most parents do not know these scores).
<i>Postnatal issues for client</i>	<input type="checkbox"/> None, left hospital in normal time frame. <input type="checkbox"/> NICU care required for _____ days: Issues included: <input type="checkbox"/> Jaundice <input type="checkbox"/> Breathing difficulties <input type="checkbox"/> Other: _____

**Medical:** (“Significant” means beyond typical childhood illnesses/experiences)

<i>Significant illnesses</i>	<input type="checkbox"/> None. <input type="checkbox"/> Yes, age _____ Type of illness: _____ Any significant/long-term change(s) in behavior after this: <input type="checkbox"/> No <input type="checkbox"/> Yes More than one significant illness: <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Significant injuries</i>	<input type="checkbox"/> None. <input type="checkbox"/> Yes, age _____ Any significant/long-term change(s) in behavior after this: <input type="checkbox"/> No <input type="checkbox"/> Yes More than one significant injuries: <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Overnight hospitalizations</i>	<input type="checkbox"/> None <input type="checkbox"/> Yes
<i>Surgeries</i>	<input type="checkbox"/> None. <input type="checkbox"/> Yes, age _____ Any significant/long-term change(s) in behavior after this: <input type="checkbox"/> No <input type="checkbox"/> Yes More than one surgery: <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Signs of seizures</i>	<input type="checkbox"/> No. <input type="checkbox"/> Unsure, may be showing signs of seizures. <input type="checkbox"/> Yes, age of first seizure _____ & most recent seizure _____ <input type="checkbox"/> Grand Mal/Tonic-Clonic. <input type="checkbox"/> Petit Mal/Absence. Typical frequency of seizures: _____
<i>Ear infections</i>	<input type="checkbox"/> Never had an ear infection. <input type="checkbox"/> A few but not on a chronic or severe basis. <input type="checkbox"/> Regularly/several. Age of first ear infection: _____ Age of last ear infection: _____
<i>Allergies</i>	<input type="checkbox"/> No environmental, food, or medication allergies are evident at this time. <input type="checkbox"/> Yes, seasonal/environmental allergies to: _____ _____ <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Treated with: _____ <input type="checkbox"/> Yes, food allergies to: _____ <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Treated with: _____ <input type="checkbox"/> Yes, medication allergies to: _____ <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Treated with: _____
<i>Asthma</i>	<input type="checkbox"/> No issues with asthma.

	<input type="checkbox"/> Yes. Frequency of attacks or needed treatment: _____ <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Treated with: _____
<i>Psychotropic medications (medications for psychological issues)</i>	<input type="checkbox"/> No psychotropic medications prescribed at this time or in the past. <input type="checkbox"/> Yes. Medication: _____ To address what issues: _____ Approximate date or age started: _____ Approximate date or age stopped: _____ If stopped, why? _____ Effectiveness <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> very good  Medication: _____ To address what issues: _____ Approximate date or age started: _____ Approximate date or age stopped: _____ If stopped, why? _____ Effectiveness <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> very good
<i>Hearing</i>	<input type="checkbox"/> Hearing never tested. <input type="checkbox"/> Hearing last tested on: _____ (Approximate age) Results: <input type="checkbox"/> Normal <input type="checkbox"/> Unknown, cooperation issues. <input type="checkbox"/> Decreased hearing.  <b>AND</b> Do you have any concern about the client's hearing, regardless of test results? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Vision</i>	<input type="checkbox"/> Vision never tested. <input type="checkbox"/> Vision last tested on: _____ (Approximate age) Results: <input type="checkbox"/> Normal <input type="checkbox"/> Nearsighted <input type="checkbox"/> Farsighted Glasses/contacts prescribed: <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>AND</b> Do you have any concern about the client's vision, regardless of test results? <input type="checkbox"/> No <input type="checkbox"/> Yes
<i>Eating patterns</i>	<input type="checkbox"/> Good, healthy appetite and he/she eats variety of foods. <input type="checkbox"/> Very picky or limited eater compared to same age peers.
<i>Sleeping-Going to bed</i>	<input type="checkbox"/> Client does not have difficulty falling asleep. <input type="checkbox"/> Client often resists or has difficulties falling asleep.
<i>Sleeping-Waking at night</i>	<input type="checkbox"/> Client typically sleeps throughout the night. <input type="checkbox"/> Client typically wakes _____ times during the night for _____ minutes, at which time they _____.  <b>AND</b> Experiences nightmares or night-terrors regularly: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure
<i>Sleeping-Length</i>	He/She usually sleeps _____ hours per night. <b>AND</b> Typically takes naps: <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ minutes a day.
<i>Pica</i>	<input type="checkbox"/> Client does not eat nonnutritive substances (i.e., sand, dirt). <input type="checkbox"/> Client mouths objects but does not try to swallow them. <input type="checkbox"/> Client will sometimes try to swallow _____.
<i>Elimination</i>	<input type="checkbox"/> Client does not experience chronic difficulties with diarrhea

	or constipation. <input type="checkbox"/> Regularly struggles with constipation. <input type="checkbox"/> Regularly struggles with diarrhea.
<i>Medical studies</i>	Genetic testing <input type="checkbox"/> Never <input type="checkbox"/> Yes, when _____ years old. MRI <input type="checkbox"/> Never <input type="checkbox"/> Yes, when _____ years old. CT (CAT scan) <input type="checkbox"/> Never <input type="checkbox"/> Yes, when _____ years old. EEG <input type="checkbox"/> Never <input type="checkbox"/> Yes, when _____ years old. Other:

**Development:**

<i>Temperament as an infant</i>	3 words to describe client as a baby:
<i>Sit up without support</i>	_____ months old.
<i>Crawled</i>	_____ months old.
<i>Walked independently</i>	_____ months old.
<i>Current motor skills</i>	<input type="checkbox"/> Good/normal or <input type="checkbox"/> Delayed/clumsy.
<i>First functional words</i>	_____ months old.
<i>Began combining words functionally (not just rote phrases)</i>	_____ months old.
<i>Current language skills</i>	<input type="checkbox"/> Good/normal or <input type="checkbox"/> Delayed or articulation difficulties.
<i>Age toilet trained</i>	<input type="checkbox"/> Not yet. <input type="checkbox"/> Yes, when _____ years old.
<i>Any periods of significant regression</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes

**Sensory Processing Issues and Activity Level:**

<i>Auditory (sounds)</i>	<input type="checkbox"/> Normal reaction to sounds for his/her age. <input type="checkbox"/> Excessive discomfort with typical daily sounds (i.e. covers his/her ears when hearing sounds that do not seem to bother most children) <input type="checkbox"/> Likes loud noises more than most children <input type="checkbox"/> Becomes very active/over-stimulated in loud or busy environments (more than most children).
<i>Visual (i.e., light)</i>	<input type="checkbox"/> Normal reaction to light. <input type="checkbox"/> Overly bothered by lights <u>on a regular basis/more than most children his/her age.</u> <input type="checkbox"/> Stares at bright lights frequently.
<i>Olfactory (smells)</i>	<input type="checkbox"/> Normal reaction to smells. <input type="checkbox"/> Reacts excessively to smells (i.e. gags, becomes distressed). <input type="checkbox"/> Almost never smells items. <input type="checkbox"/> Smells items excessively/too often. <input type="checkbox"/> Smells unusual items regularly (other people, carpet, etc.)
<i>Oral/Foods</i>	<input type="checkbox"/> Normal food preferences for age. <input type="checkbox"/> Very picky about food, but there is no consistent pattern to the texture of temperature of their food preferences. <input type="checkbox"/> Very particular about food texture: <input type="checkbox"/> Only likes crunchy food <input type="checkbox"/> Only likes soft foods <input type="checkbox"/> Will not tolerate mixed textures <input type="checkbox"/> Other <input type="checkbox"/> Overly particular about food temperature.
<i>Tactile (touch)</i>	<input type="checkbox"/> Normal reaction to touching various textures, such as sand,

	<p>dirt, Play-Doh, finger-paints, etc.</p> <input type="checkbox"/> Becomes upset/uncomfortable when touching: _____
<i>Clothes</i>	<input type="checkbox"/> Normal preference/pickiness of clothes for age. <input type="checkbox"/> Strongly prefers only soft clothes. <input type="checkbox"/> Very bothered if clothes are a little too tight or loose. <input type="checkbox"/> Frequently bothered by tags, buttons, or other textures. <input type="checkbox"/> Unusual clothes preferences, such as only long pants/shirts, shirts must have hoods, etc.
<i>Vestibular (movement)</i>	<input type="checkbox"/> Normal enjoyment of swinging, spinning, and sliding. <input type="checkbox"/> Greatly dislikes swinging, spinning, and sliding. <input type="checkbox"/> Excessively likes swinging, spinning, and slides.
<i>Proprioceptive (pressure)</i>	<input type="checkbox"/> Normal reaction to pressure, such as from tight hugs. <input type="checkbox"/> Greatly dislikes tight pressure, such as from hugs, heavy blankets, etc. <input type="checkbox"/> Excessively seeks tight pressure, such as from tight hugs, wedging him/herself between objects, heavy jackets, etc.
<i>Pain tolerance</i>	<input type="checkbox"/> Normal reaction to pain (depends on reaction of others and if blood is seen). <input type="checkbox"/> Unusually high pain tolerance <u>on a regular basis</u> (does not feel pain easily). <input type="checkbox"/> Unusually low pain tolerance <u>on a regular basis</u> (feels pain too easily).
<i>Over or under active</i>	<input type="checkbox"/> Normal activity level for age (most children have spurts of hyperactivity, or periods of lethargy). <input type="checkbox"/> Unusually <u>high</u> activity level on a regular basis. <input type="checkbox"/> Unusually <u>low</u> activity level on a regular basis.
<i>Focus or attention span</i>	<input type="checkbox"/> Normal attention span for age. <input type="checkbox"/> Very short attention span and rarely focuses on anything for more than _____ minutes. <input type="checkbox"/> Attention span is very short when others are trying to get him/her to focus, but it is excessively strong on objects of interest to him/her.

**Education History:**

<i>Early intervention services (0 to 3 years old)</i>	<input type="checkbox"/> No special services prior to three years of age. <input type="checkbox"/> Client received early intervention services from (agency) _____ when _____ months to _____ months old, during which time he/she received _____ therapy.
<i>Daycare</i>	<input type="checkbox"/> Client has never attended a private daycare. <input type="checkbox"/> Client attended daycare from _____ to _____ years of age. _____ days per week for average of _____ hours per day.
<i>Services/programs between 3 and 5 years old</i>	<input type="checkbox"/> Client did not receive any specialized services at this age. <input type="checkbox"/> Client attended _____ preschool from _____ to _____ years of age for _____ days per week for average of _____ hours per day.
<i>Elementary school</i>	Client began attending kindergarten when _____ years old.
<i>Current grade &amp; school</i>	CN currently attends _____ grade in a <input type="checkbox"/> mainstream classroom <b>OR</b> <input type="checkbox"/> special education classroom.

<i>Special education services</i>	<input type="checkbox"/> Client has never been evaluated for or qualified for special education services. <input type="checkbox"/> Client qualified for special education services under the category of _____ when _____ years old.
<i>Behavioral difficulties within current school program</i>	<input type="checkbox"/> No significant issues at school. <input type="checkbox"/> Yes, including: _____
<i>Speech therapy</i>	<input type="checkbox"/> Never received this service. <input type="checkbox"/> Yes, from _____ years old to _____ years old, approximately _____ times per week for _____ minutes per session.
<i>Occupational therapy</i>	<input type="checkbox"/> Never received this service. <input type="checkbox"/> Yes, from _____ years old to _____ years old, approximately _____ times per week for _____ minutes per session.
<i>Developmental therapy</i>	<input type="checkbox"/> Never received this service. <input type="checkbox"/> Yes, from _____ years old to _____ years old, approximately _____ times per week for _____ minutes per session.
<i>Other therapy</i>	Any other therapies? , i.e. music, saddle pals, developmental therapy, etc. <input type="checkbox"/> No <input type="checkbox"/> Yes, including: _____
<i>Extracurricular activities</i>	Such as swimming, musical instrument, Karate, scouts, etc? <input type="checkbox"/> No <input type="checkbox"/> Yes, including: _____

**Behavior & Psychological Issues:**

<i>Suicidal/homicidal ideation</i>	<input type="checkbox"/> None heard/reported. <input type="checkbox"/> Yes.
<i>History of abuse or trauma</i>	<input type="checkbox"/> Client has never been a victim of either. <input type="checkbox"/> Yes.
<i>Family history of learning disorders</i>	<input type="checkbox"/> No family history of learning disorders. <input type="checkbox"/> Yes, there are family members with learning issues.
<i>Family history of psychological disorders</i>	<input type="checkbox"/> No family history of psychological disorders. <input type="checkbox"/> Yes, there are family members with psychological issues.
<i>Attempts to hurt himself/herself</i>	<input type="checkbox"/> No self-injurious behaviors by client. <input type="checkbox"/> Yes, client will try to hurt self.
<i>Attempts to hurt others</i>	<input type="checkbox"/> No excessive aggressive behaviors towards others. <input type="checkbox"/> Yes, client is aggressive towards others at times.
<i>Behavioral difficulties; i.e., tantrums</i>	<input type="checkbox"/> At an age-appropriate level. <input type="checkbox"/> Client typically tantrums _____ times per day, during which time he/she will _____. This is typically triggered by _____.
<i>Mental health services</i>	<input type="checkbox"/> Never attending counseling/therapy. <input type="checkbox"/> Yes, attended when _____ years old for _____ # of sessions.

**PDD: Pervasive Developmental Disorder (PDD), such as autism or Asperger's.**

<i>Current and prior diagnosis by other professionals</i>	<input type="checkbox"/> Client has never previously been evaluated for a PDD. <input type="checkbox"/> Dr. _____ evaluated client when _____ years old and diagnosed him/her with _____. Client has had more than one diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

Parent's Notes/Comments: