Child and Adolescent History Form

Appointment:

Please bring this completed form with you at the time of your appointment: _____

Referral Information:

Child's name: _____ Date Completed: _____

Child's Birth Date: _____ Age: _____ Sex:_____

Home Address: _____

Home Phone Number: _____

Child's Cell Phone Number:_____

Parent's Name _____Work Number: _____

Cell Number: _____

Parent's Name: _____Work Number: _____

Cell Number: _____

Who referred you? _____

Person completing this form: _____

Describe your concerns about your child: _____

_____

_____

_____

Email Addresses:

Mother: _____

Father: _____

Child: _____

Give a brief history of these concerns (length of time you have been concerned, a description of any factors you think may be contributing to the difficulty, previous attempts to resolve these issues):

_____

_____

_____

_____

What goals do you have for your child's assessment and/or treatment?

_____

_____

Briefly describe your child's strengths:

_____

_____

_____

_____

What does your child enjoy doing the most?

_____

_____

What extra-curricular activities or hobbies does your child participate in?

_____

_____

List any major stresses or changes that have occurred to your child or family in the past several years:

_____

_____

Indicate past and current counseling or evaluation services your child has received:

Counselor	Dates Seen	Records Available
_____	_____	Y/N_____
_____	_____	Y/N_____
_____	_____	Y/N_____

SCHOOL INFORMATION

Child's School _____Grade _____

Address or School _____

_____

School Phone Number _____

Describe your child's academic strengths: _____

_____

Describe areas of academic concern for your child:_____

_____

How would you rate your child's overall intelligence level compared to other children?

____ below average ____ average ____ above average ____ gifted

To the best of your knowledge, at what grade level is your child functioning?

Reading _____ Spelling _____ Writing _____ Math _____

School Achievement/Ability resting results (if known): _____

_____

List other schools your child has previously attended:

School _____Years _____

School _____Years _____

School _____Years _____

At what age did you child enter Kindergarten? _____

Has your child ever repeated a grade? _____

Present grade placement: regular class _____ or special class _____

If special class, please specify Intensity Level (I-VI) and educational diagnosis: _____

_____

Does your child currently receive any remedial services at school or other facilities:_____

Specify: _____

Describe any concerns raised by your child's current or past teachers: _____

_____

Background Information

Pregnancy

Is your child adopted? _____ If yes, at what age? _____

How long was the pregnancy? _____Birth Weight: _____

Delivery

Indicate any complications during delivery: _____

_____

Indicate any problems or special treatment required for your infant at the time of birth:

_____

_____

Developmental History

Infant/Toddler

Describe your child's temperament as an infant/toddler, (e.g. easy, cuddly, underactive, overactive, colicky, difficult to soothe, etc): _____

_____

Indicate the age at which your child reached the following developmental milestones. If you cannot recall exactly, indicate early, normal or late relative to typical development:

Walked _____

Spoke first words _____

Said phrases _____

Toilet trained (day) _____

Toilet trained (night) _____

Dressed self _____

Tied shoes _____

Indicate with a checkmark any difficulties your child exhibited as an infant/toddler that seemed excessive when compared to other children:

____ restlessness

____ frequent head banging

____ constantly into everything

____excessive accidents

____ poor speech articulation

____ delayed language development

____ floppy or stiff

____ poor coordination

____ poor weight gain

____ poor eye contact

____ feeding problems

____ other (specify) _____

Please describe any major life stresses that occurred to your child or family during your child's infancy or early childhood: _____

_____

Briefly describe the style of parenting used in the household by both parents: _____

_____

_____

Describe how your child is disciplined: _____

_____

_____

For what reasons is the child disciplined? _____

_____

_____

List your child's main difficulties at home:

1. _____
2. _____
3. _____

Briefly describe your child's friendships:

_____

_____

_____

Child's Medical History and Status

Primary Care Physician: Name: _____

Address: _____

_____

Phone: _____

Child's current height: _____ Current weight: _____

Present or chronic illnesses for which the child is being treated:_____

_____

Medications that the child is currently taking (indicate dosage and prescribing physician):

_____

_____

Please indicate with a checkmark if you child's medical history includes any of the following:

____ complications of childhood diseases

____ cuts and stitches (how many times? ____)

____ broken bones (how many times? ____)

____ serious illnesses

____ hospitalizations

____ mild or major head injuries

____ poisoning

____ persistent high fevers

____ allergies

____ other (specify) _____

____ seizures

____ comas

____ eye problems

____ ear infections

____ ear tubes

____ tonsils out

____ adenoids out

____poor muscle coordination

____ overweight

____ underweight

Please provide details concerning checked items: _____

_____

_____

_____

Is there any history of sexual or physical abuse? _____; If yes, please specify: _____

_____

Behavioral Information

All children exhibit, to some degree, some of the behaviors listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compare to other children.

Feelings
____ moody
____ sad
____ lack of enjoyment
____ underactive
____ low energy
____ dislikes self/low self-esteem
____ feels unloved
____ death ideas
____ past/present suicidal ideas
____ overexcitement

Learning Issues
____ has difficulty grasping concepts
____ doesn't seem to understand directions
____ poor memory
____ does not seem to work to potential
____ perfectionist
____ doesn't seem motivated
____ difficulty expressing self
____ difficulty with small motor skills
____ difficulty with gross motor skills

Behavioral Issues
____ losses temper
____ argues
____ non-compliant or disobedient
____ annoys others
____ blames others for mistakes
____ easily annoyed
____ angry
____ spiteful
____ bullies, threatens, or hurts others
____ cruelty to animals
____ stealing
____ fire-setting/match play
____ lying
____ truancy
____ running away
____ violates parental rules

Communication
____ hard to understand child
____ has difficulty understanding others
____ stuttering
____ fails to speak in some settings

Activity and Attention
____ careless mistakes
____ poor attention span
____ does not seem to listen
____ does not complete tasks
____ disorganized
____ loses things
____ easily distracted
____ forgetful
____ overactive, fidgety
____ can't stay in seat
____ acts as if "driven by a motor"
____ overly talkative
____ interrupts
____ difficulty waiting turn

Worries
____ fearful
____ excessively shy
____ afraid to leave parent
____ afraid in new situations
____ frequent worrying
____ panicky
____ repetitive behavior
____ thumb-sucking
____ nail-biting
____ irritable
____ needs much reassurance

Social Issues
____ has few or no friends
____ teased by others
____ avoids other children
____ rejected by others
____ acts younger than age
____ acts older than age
____ difficulty sharing
____ unusual or "odd"child
____ bossy
____ withdrawn
____ poor bond with parent (s)

Other
____ eating problems
____ sleeping problems
____ wetting problems
____ fecal soiling
____ jealous of siblings
____ tics or "funny" movements

Please specify other concerns: _____

_____

Family History

Household

People with whom the child lives (specify parent, step-parent, sibling, half-sibling, step-sibling, Grandparent, etc.)

	Name	Age	Relationship	Medical/School/Behavior concern
1.				
2.				
3.				
4.				
5.				
6.				

Other immediate family members with whom the child does not live:

	Name	Age	Relationship	Medical/School/Behavior concern
1.				
2.				
3.				

How long have you lived at the current address? _____

Language spoken at home: _____

If parents are separated or divorced, child's age at time of separation/divorce:_____

Who has legal custody of child? _____ Describe living/visitation arrangements for child: _____

Mother's History

Mother's full name: _____ Age: _____

Occupation: _____

Place of Employment: _____Number of years: _____

School: Highest grade completed: _____

Degree Completed: _____

Learning or behavioral problems: _____

Medical Problems: _____

Specify mental health concerns (past and present): _____

Specify past counseling experiences: _____

Medical/Psychiatric medications: _____

Medical/Psychiatric hospitalizations: _____

Specify past or present legal difficulties: _____

Specify past or present difficulties with alcohol or substance use: _____

_____

Reproductive History:

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

Number of therapeutic abortions: _____

Father's History

Father's full name: _____ Age: _____

Occupation: _____

Place of Employment: _____Number of years: _____

School: Highest grade completed: _____

Degree Achieved: _____

Learning or behavioral problems: _____

Medical Problems: _____

Specify mental health concerns (past and present): _____

Specify past counseling experiences: _____

Medical/Psychiatric medications: _____

Medical/Psychiatric hospitalizations: _____

Specify past or present legal difficulties: _____

Specify past or present difficulties with alcohol or substance use: _____

_____

_____

Extended Family History

Please indicate with a checkmark whether there is any family history of any of the following difficulties. Include parents, sibling, grandparents, aunts, uncles, cousins. If present, please specify relationship.

Difficulty	**Relationship**
_____ Mental Retardation	_____
_____ Attention Deficit Disorder or Attention Problems	_____
_____ Tourette's syndrome or Tic Disorder	_____
_____ Learning Problems/Failure	_____
_____Communication Disorder	_____
_____ Autism	_____
_____ Anxiety Problems	_____
_____ Obsessive Compulsive/Repetitive Behaviors	_____
_____ Depression	_____
_____ Suicide Attempt	_____
_____ Sexual or Physical Abuse	_____
_____ Drug Abuse	_____
_____ Alcoholism	_____
_____ Legal Difficulties	_____
_____ Schizophrenia	_____
_____ Psychiatric Hospitalizations	_____
_____ Use of Psychiatric Medication	_____
_____ Thyroid Problems	_____
_____Genetic/Metabolic Disorders	_____
_____ Other Mental Health Concern	_____

Additional Comments:

Please use the space below to describe any other information you feel would be helpful to us in understanding your child and your concerns.

_____

_____

_____

_____