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Child and Adolescent History Form

The information requested in this form is treated as CONFIDENTIAL. The questions are designed to help us understand your concerns about your child or adolescent. If you have any questions about the requested information, please do not hesitate to ask me.

Child/Adolescent's: Birth date: _____ Age: _____ Grade: _____

Address: _____

Zip Code: _____

Parent/Guardian's Phone: Home: () _____ Work: () _____

Parent'/Guardian's Work Hours: _____

Father's Name: _____

Age: _____ Education: _____ Occupation: _____

Mother's Name: _____

Age: _____ Education: _____ Occupation: _____

Are the above named the child/adolescent's: Biologic Parent(s) Adoptive Parent(s) Stepparent

OTHER GENERAL FAMILY INFORMATION

- Is the child/adolescent adopted? No Yes

If Yes, at what age was he/she adopted? _____

If Yes, does he/she know of the adoption? _____

- Please list all persons living in the home with the child/adolescent whom we will be evaluating.

Names of Current Residents	Age	Relationship to Child/Adolescent
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- Are the child/adolescent's parents separated or divorced? No Yes If Yes, answer the following questions.

- When did separation occur (month/year)? _____

- When was the divorce final (month/year)? _____

- Who has legal custody? _____

- Who has physical custody? _____

Other General Family Information (Cont'd)

- Does the noncustodial parent:
 Know of this Evaluation Have Regular/Frequent Contact with Son/Daughter
 Have Limited/Unpredictable Contact Insure the Child/Adolescent
- If the child/adolescent **does not** live with biologic or adoptive parent(s), please provide the following information regarding guardianship.

Are you:

- A Foster Parent(s)
- A legal guardian(s) who is a biologic relative: State relationship _____
- A legal guardian(s) who is not a biologic relative

Foster Parent/Guardian's Name: _____

Address: _____ Phone: (____) _____

_____ Zip Code: _____

- Please state why child/adolescent is in foster care or with a guardian. _____

PLEASE STATE THE PROBLEM(S) YOUR CHILD/ADOLESCENT IS EXPERIENCING WHICH LED YOU TO SEEK HELP. _____

DID ANYONE SUGGEST/REQUIRE YOU TO SEEK HELP FOR YOUR CHILD/ADOLESCENT?

NO YES IF YES, WHO AND FOR WHAT REASON(S) IF DIFFERENT FROM THE ABOVE REASON.

GENERAL BEHAVIOR

- Please check any items below which describe your child/adolescent's typical behavior. That is, how he/she is most of the time.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Friendly, Outgoing | <input type="checkbox"/> Prefers Company | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Respectful |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Prefers to be Alone | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Defiant |
| <input type="checkbox"/> Easygoing, Calm | <input type="checkbox"/> Optimistic | <input type="checkbox"/> Confident | <input type="checkbox"/> Takes Risks |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Pessimistic | <input type="checkbox"/> Expects Failure | <input type="checkbox"/> Cautious |
| <input type="checkbox"/> Hardworking | <input type="checkbox"/> Caring | <input type="checkbox"/> Sharing | <input type="checkbox"/> Generally Happy |
| <input type="checkbox"/> Lazy | <input type="checkbox"/> Uncaring | <input type="checkbox"/> Selfish | <input type="checkbox"/> Generally Unhappy |

PROBLEM BEHAVIORS

- Please check any of the behaviors which occur excessively or frequently now and/or in the past.
 - Worries
 - Fears
 - Obsessive Thoughts
 - Compulsive/Repetitive Behavior
 - Odd Thoughts
 - Odd Behavior
 - Disturbing Thoughts
 - Nightmares
 - Night terrors
 - Insomnia
 - Sleepwalking
 - Will Not Sleep Alone
 - Missing School Due to Illness
 - Frequent Physical Complaints
 - Skipping Classes/School
 - Legal Problems
 - Runs Away from Home
 - Tantrums, Angry Outbursts
 - Bullies
 - Argues
 - Defiant/Op positional
 - Fights
 - Lies
 - Steals
 - Destroys property
 - Sets Fires
 - Cruelty to Animals
 - Sexual Activity
 - Reckless/Careless Behavior
 - Mood Swings
 - Disruptive Behavior
 - Sadness
 - Depression
 - Crying Spells
 - Irritable
 - Withdrawn
 - Boredom
 - Significant Appetite
 - Accident Prone
 - Short Attention Span
 - Distractible
 - Impulsive
 - Hyperactive
 - Learning Problems
 - Speech Problems
 - Poor School Work

For Clinician's Use. _____

• Has your child/adolescent ever talked about or attempted suicide? No Yes If Yes, when and what were the circumstances. _____

• Has your child/adolescent ever talked seriously about hurting or killing someone/something, or done so? No Yes If Yes, when and what were the circumstances. _____

• To your knowledge has your child/adolescent ever been physically abused? No Yes If Yes, when and what were the circumstances. _____

• Has your child/adolescent ever been the victim of sexual abuse? No Yes If Yes, please explain. _____

• Has your child/adolescent ever used alcohol and/or drugs? No Yes If Yes, please be sure to complete the substance abuse questions in the last section of this history form (page 11).

BIRTH TO FIVE YEAR DEVELOPMENTAL HISTORY

• Mother's Pregnancy: Normal Complicated [Explain] _____

• Check any substances the biologic mother used during her pregnancy and comment on any item checked.

Tobacco Alcohol Drugs Medications

• Check any of the following that pertain to the biologic mother's delivery:

Full Term Vaginal Delivery Premature C-Section Fetal Distress

Please explain any complications. _____

• Child's condition at birth: Normal Abnormal

If Abnormal, please explain. _____

• Birth Weight: _____ lbs. _____ oz.

• As an infant was your child/adolescent:

Easy to Manage Irritable Demanding
 Alert/Responsive A Poor Eater A Poor Sleeper

• At what age did your child:

Sit up unassisted: _____ Walk without support: _____ Use first words: _____

Use sentences: _____ Toilet trained for daytime: _____ Dry at night: _____

• Was toilet training easy or difficult? Easy Difficult

• Does your son/daughter: Bed wet Daytime wet Soil and/or has bowel movements in underclothing

Please comment on any checked item. _____

• By or before the time your child entered kindergarten did you, your child's physician or any of your child's preschool teachers have concerns about any of the following areas of development?

Language Development [Use of words and sentences] Balance/Coordination Vision
 Speech Development [Pronunciation] Behavior Problems Intelligence
 Fine Motor Development [pencil grip, coloring, cutting, etc.] Hearing

SCHOOL HISTORY

Current School: _____ Phone: (____) _____

Address: _____

_____ Zip Code: _____

• Has your child/adolescent repeated a grade? No Yes If Yes, which grade (s)? _____

• Has your child/adolescent been assessed for special education services? No Yes If Yes, when? _____

• Is your child/adolescent receiving Special Education services now? No Yes If Yes, what type of Special Education? _____

• Was your child/adolescent in Special Education in past years? No Yes If Yes, when and what type of special education was he/she certified to receive? _____

SCHOOL HISTORY(cont'd)

• Please write in the school or district (i.e., city, township, different state) attended by your child/adolescent for each grade, and the usual marks attained. Check any of the problems listed for each of the grades in which they occurred. Please list any repeated grades on the blank lines below.

Grade	School District	Academic Grades	Learning Probs.	Peer Probs.	Short Attention Span	Hyper-activity	Behavior Probs.	Expelled or Suspended
K	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY CULTURAL AND/OR ETHNIC INFORMATION

• As a family, do you identify yourself with a particular cultural or ethnic group? No Yes If Yes, please note cultural/ethnic identification and the influence or role it plays in family life. _____

RELIGIOUS AND/OR SPIRITUAL INFORMATION

• Do you regularly attend church as a family? Yes No
 • What is the Religious/Spiritual Orientation of your family? _____
 • How does your religious/spiritual orientation affect family life? _____

SOCIAL/RECREATIONAL/STUDY TIME INFORMATION

• How many hours per week does your son/daughter spend in social/leisure time activities? _____
 • Is your son/daughter involved in any organized sports or recreational activities? No Yes If Yes' please note what activities and how many hours per week. _____
 • How many hours does your child spend using social media (Facebook, Twitter, etc.)? _____
 • Has your child ever had any problems with social media? Please describe _____

- How many hours per week does your son/daughter study and/or do homework? _____

SEXUAL INFORMATION

The focus in this section is on pre-adolescent and adolescent behavior/experience, and in most cases will not apply to young children.

- Is your son/daughter sexually active? No Yes If Yes, please explain. _____

- Has your son/daughter ever contracted a sexually transmitted disease? No Yes If Yes, please explain.

- Has your daughter ever been pregnant, had an abortion, or given birth to a child? No Yes If Yes, please explain. _____
- Has your son ever been involved in sexual activity that resulted in a female becoming pregnant? No Yes If Yes, please explain. _____
- What are the sources of sexual information available to your son/daughter (i.e., parents, educational programs, church, etc.)? _____
- As parents or guardians, do you have any specific concerns regarding sexual matters (i.e., educational, sexual behavior of son/daughter, sexual orientation of son/daughter, etc.)? No Yes If Yes, please state your concerns.

ADOLESCENT WORK HISTORY

- Did/does your adolescent hold a job? No Yes If Yes, please list his/her employment history below beginning with the current or most recent job, and work back through his/her job history.

Employer	Dates	Job Description
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Has your son/daughter experienced any work related problems? No Yes If Yes, please explain.

LEGAL INFORMATION

- Is your son/daughter involved in any civil or criminal legal proceedings? No Yes If Yes, please explain. _____

- Has your son/daughter ever been charged/arrested for any offense in which drugs or alcohol been involved? No Yes If yes, please explain. _____

- Is your son/daughter presently on probation? No Yes If Yes, please explain. _____

LEGAL INFORMATION (cont'd)

• If your son/daughter is on probation, please provide the name, address, and phone number of his/her probation officer.

Name: _____
Address: _____
_____ Zip Code: _____
Phone: (____) _____

• Does your son/daughter have any history of the following? No Yes If Yes, check any that applies and explain below.

- Suspended/revoked drivers license DUI/DWI Minor in possession of alcohol/drugs
- Conviction for misdemeanor Conviction for felony Shoplifting
- Other: _____

Explanation: _____

SIGNIFICANT LIFE EVENTS

• Please check any of the following events which have occurred in your child/adolescent's life and his/her age when it occurred.

Event or Situation	Age	Event or Situation	Age
<input type="checkbox"/> Change of residence	_____	<input type="checkbox"/> Family gambling problems	_____
<input type="checkbox"/> Change of schools	_____	<input type="checkbox"/> Family psychiatric problems	_____
<input type="checkbox"/> Change of custody	_____	<input type="checkbox"/> Family chronic illness	_____
<input type="checkbox"/> Marital conflict	_____	<input type="checkbox"/> Other family problems	_____
<input type="checkbox"/> Parents separated	_____	<input type="checkbox"/> Rejection by family member(s)	_____
<input type="checkbox"/> Parents divorced	_____	<input type="checkbox"/> Abuse to self (verbal, physical, sexual)	_____
<input type="checkbox"/> Parent visitation problems	_____	<input type="checkbox"/> Witnessed abuse to others	_____
<input type="checkbox"/> Post divorce parent conflict	_____	<input type="checkbox"/> Victim of abuse	_____
<input type="checkbox"/> Parent(s) remarried	_____	<input type="checkbox"/> Suffered/Witnessed significant accident or injury	_____
<input type="checkbox"/> Step parent problems	_____	<input type="checkbox"/> Other severe fright or trauma	_____
<input type="checkbox"/> Sibling birth	_____	<input type="checkbox"/> Death of family member or friend	_____
<input type="checkbox"/> Acquired step sibling(s)	_____	<input type="checkbox"/> Suicide of family member or friend	_____
<input type="checkbox"/> Family economic problems	_____	<input type="checkbox"/> Death or pet	_____
<input type="checkbox"/> Family job problems	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Family substance abuse	_____		

PREVIOUS PSYCHIATRIC AND/OR CHEMICAL/DEPENDENCY TREATMENT HISTORY

• Has your child/adolescent received any psychiatric or chemical dependency treatment in the past? No Yes If Yes, please indicate in the space provided below.

TYPE OF TREATMENT	DATES	TREATMENT FACILITY & THERAPIST
Outpatient Psychiatric	_____	_____
	_____	_____
	_____	_____

PREVIOUS PSYCHIATRIC AND/OR CHEMICAL/DEPENDENCY TREATMENT HISTORY (cont'd)

Inpatient Psychiatric	_____	_____
	_____	_____
Outpatient Chemical Dependency	_____	_____
	_____	_____
Inpatient Chemical Dependency	_____	_____
	_____	_____

FAMILY PSYCHIATRIC & SUBSTANCE USE HISTORY

- Please check any family members with a history of difficulties in the areas noted.

RELATIONSHIP	DEPRESSION	MANIA	ANXIETY	PSYCHOSIS	ADHD	ALCOHOL/DRUGS
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY MEDICAL HISTORY

- Please check any family members with a history of difficulties in the areas noted.

RELATIONSHIP	CHRONIC MEDICAL PROBLEMS	NEUROLOGIC DISORDERS	SEIZURE DISORDER	THYROID DISORDER	MENTAL RETARDATION
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Please make any additional comments you feel might be relevant regarding family members' psychiatric, chemical substance abuse, or medical history.

MEDICAL HISTORY

- Are your child/adolescent's immunizations current? Yes No Unsure

- Date of most recent physical _____ Results: Normal Other [Explain]

MEDICAL HISTORY (cont'd)

- What is your son/daughter's current: Height _____ Weight _____
- **Please check any of the following medical or physical conditions that apply to your child/adolescent.**

<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Cardiac Problems	<input type="checkbox"/> Significant Weight Gain
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Frequent Vomiting
<input type="checkbox"/> Gross Motor Coordination Problems	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Fine Motor Coordination Problems	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> History of Migraines
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Stomach Aches
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Allergies	<input type="checkbox"/> Frequently Ill
<input type="checkbox"/> History of Febrile Seizures	<input type="checkbox"/> Chronic Ear Infections	<input type="checkbox"/> Loss of Menstruation (Amenorrhea)
<input type="checkbox"/> History of Meningitis	<input type="checkbox"/> Tics (Twitches)	<input type="checkbox"/> Failure to thrive or growth retardation
<input type="checkbox"/> History of Encephalitis	<input type="checkbox"/> Significant Weight Loss	<input type="checkbox"/> Other _____
- Is your child/adolescent currently taking any medication(s)? No Yes If Yes, please list name of medications and daily dosage.

- Has your child/adolescent been hospitalized for medical treatment? No Yes If Yes, when and for the treatment of what condition.

- For Girls: Menstrual periods began at age _____ Any problems? No Yes If Yes, please explain.

Please provide the following information about your child/adolescent's physician

Name: _____

Address: _____

_____ Zip Code: _____

Phone (_____) _____

SUBSTANCE ABUSE HISTORY

This section is to be completed if the patient to be seen has a history or suspected history of substance abuse.

- Please list any chemical substances you know, or suspect, your son/daughter has taken.

Name of Substance	Age when use was discovered or suspected
_____	_____
_____	_____
_____	_____

- Check those items that apply to your knowledge of your son/daughter. While many apply directly to substance use, please keep in mind that substance abuse is only one possible explanation for the behavioral changes noted.

- Witnessed intoxication/high
- Found alcohol (e.g., empty or partially empty bottles, alcohol missing from the home)
- Found drugs in or outside of the home or in his/her possession
- Alcohol/drug use reported by neighbors, friends, or a family member
- Reports of alcohol/drug use by school personnel
- Reports of alcohol/drug use by the police
- Found drug paraphernalia
- Significant negative change in personality
- Extreme, irrational mood swings
- Extreme isolation/withdrawal from family
- Increased conflict/tension with family members
- Increased conflict/tension with peers
- A decrease in school grades, attitude, and motivation
- Decreased interest in hobbies, sports, and recreation
- A change in peer group or tendency to keep friends a secret
- Missing money or valuables from the home and/or stealing outside the home

-
-
- Relationship of Adult Completing Form to the Child/Adolescent to be seen in Clinic:

Parent Foster Parent Guardian Other: _____

Signature of Adult Completing Form

Date

Signature of Clinician Reviewing Form

Date