CHILD & ADOLESCENT HISTORY

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Parent, please fill in completely.

Child's Name: _____ DOB: _____ Age: ___ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Parent's Work Phone: _____

FAMILY INFORMATION

Father _____ Age _____ Occupation _____

Religion _____ Education _____ Married_____ Divorced _____ Deceased _____
Year Year Year

Mother _____ Age _____ Occupation _____

Religion _____ Education _____ Married_____ Divorced _____ Deceased _____
Year Year Year

Stepfather _____ Age _____ Occupation _____

Religion _____ Education _____ Married_____ Divorced _____ Deceased _____
Year Year Year

Stepmother _____ Age _____ Occupation _____

Religion _____ Education _____ Married_____ Divorced _____ Deceased _____
Year Year Year

Legal Guardian: _____ _____
Name Relationship

Address: _____ City: _____ State: _____ Zip: _____

Brothers and Sisters			
Name	Sex	Age	Where they are now living

Other People Living in the Home			
Name	Sex	Age	Relation to Child/Adolescent

Is your child/adolescent adopted? Yes _____ No _____ Circumstances:_____

Does child/adolescent know that he or she has been adopted? _____

Family history of mental/emotional problems (describe): _____

Family history of alcohol or drug problems (describe): _____

Family history of legal problems (describe): _____

Family history of suicide attempts (describe): _____

PREGNANCY

Describe mother's health during pregnancy: _____

What drugs (including alcohol) were taken during pregnancy? _____

Stress experienced during pregnancy: _____

BIRTH & EARLY DEVELOPMENT

How long did labor last? _____ Labor induced? _____ Caesarian birth? _____ Full-term? _____

Child's Birth weight: _____ Problems breathing? _____ Treatments: _____

Was baby breast-fed, bottle-fed or both? _____ Problems with nursing or formula: _____

Age baby completely weaned: _____ Describe baby's activity level: _____

Stressful events in family during baby's first year: _____

CHILD DEVELOPMENT

At what age did child first walk without support? _____ Age child began babbling and cooing? _____

At what age did child first speak words? _____ Simple sentences? _____

Did child have difficulty speaking? _____ Age: _____ Speech therapy? _____

Age child stopped wetting bed: _____ Did baby smile by six months? _____

Described any questions or comments child has had about sex: _____

At what age did temper tantrums begin? _____ Describe: _____

Who currently disciplines child/adolescent? _____ How? _____

Describe childhood fears and how they were handled: _____

Describe any sleep disturbances: _____

Describe any eating problems: _____

Has child/adolescent used drugs or alcohol? _____ Explain: _____

How many times has child/adolescent moved? _____ What ages? _____

Describe any history of neglect, physical abuse or sexual abuse: _____

List several significant events in child/adolescent's life: _____

Sensitivities to light, noise, how things feel or temperature: _____

List previous psychiatric diagnoses: _____

SYMPTOM CHECKLIST

1. Please check each symptom experienced within the past TWO MONTHS.
2. Then <u>circle</u> the top six to eight symptoms.

___ Depressed mood
___ Decreased motivation
___ Feels hopeless or helpless
___ Decreased energy
___ Irritable mood
___ Mood swings
___ Withdrawn
___ Increased crying
___ Suicidal thoughts
___ Suicidal attempt
___ Self-abusive behavior
___ Conduct problem
___ Harms others
___ Stealing
___ Poor social skills
___ Defiant/Disobedient
___ Easily startled
___ Poor coordination
___ Repetitive behavior
___ Obsessive thoughts
___ Compulsive behavior
___ Nightmares
___ Anxiety/Worry
___ Intense fear
___ Short attention span
___ Hyperactivity
___ Impulsive
___ Daydreaming
___ Indecisive
___ Memory problem
___ Temper outbursts
___ Insomnia
___ Lying
___ Eating problem
___ Perfectionism
___ Watches for danger
___ Unusual body movement
___ Poor eye contact
___ Hears voices
___ Sees things that are not there
___ Racing thoughts
___ Increased energy
___ Sexual problem
___ Stomach aches
___ Headaches
___ Conflicts with peers
___ Urination or bowel problems
___ Socially withdrawn
___ Fatigue
___ Pulls out hair, eyebrows or eyelashes
___ Change of appetite
___ Fire setting
___ Aggressive Behavior
___ Poor concentration
___ Exposed to life threatening event

SCHOOL

Name of child's school: _____

Circle your child's current grade placement: K 1 2 3 4 5 6 7 8 9 10 11 12 Other: _____

Describe current problems in school: _____

Explain when these problems began: _____

Circle *current* grades: A B C D F Circle grades from *last school year*: A B C D F

Describe any history of learning disabilities: _____

Describe any special program child involved with in school: _____

Has anyone ever said your child/adolescent is hyperactive or has attention problems? _____

Describe any grade failures or retentions:_____

SOCIAL How many friends does you child now have? _____ Plays with other children? _____

Describe your child's social interactions: _____

Circle which words describe your child's social behavior: Aggressive Bossy Follower Makes friends easily
Flat tone of voice Shy Quiet or Loud Plays with younger or older children? _____

HEALTH HISTORY (Please fill in completely, even if some things do not seem important)

Illnesses & Hospitalizations	Age	Length	Fever – Unconscious?	Treatment & Aftereffects

Accidents	Age	Unconscious?	Treatment & Aftereffects

List all **medications** child/teen now taking	Name of Dr. prescribing	Purpose of medication
		Use back of page if needed.

Head injuries? ____ No ____ Yes Explain: _____

Seizures? _____ No _____ Yes Explain: _____

High Fevers _____ No _____ Yes Explain: _____

Describe any history of ear infections: _____

List current medical problems: _____

RELIGIOUS

Church affiliation: _____

Describe child's level of participation in religious activities: _____

SUBSTANCE ABUSE

When did your child/adolescent first drink alcohol? _____

Describe his/her current alcohol use: _____

Describe any illegal drug use: _____

THERAPY/GOALS

Describe any previous involvement with therapy or counseling: _____

What concerns you most about your child/adolescent at this point? _____

_____

Why are you <u>now</u> bringing your child/adolescent in for evaluation or therapy (versus before or later)?

_____

Describe how each parent feels about child/adolescent being seen in our office: _____

_____

ADDITIONAL COMMENTS: _____

_____

_____ _____ _____

Signature Relationship to child/adolescent Date