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, so that we may be able to assist you. If you have any questions about the requested information, please do not hesitate to ask us.

Child/Adolescent's Name: ____

Address: ____ Zip Code: _________

Birth date: ________________________ Age: _____ Grade: _________

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

- 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. ____

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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.

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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.

☐ Friendly, Outgoing	☐ Prefers Company	☐ Cooperative	☐ Respectful
☐ Shy	☐ Prefers to be Alone	☐ Stubborn	☐ Defiant
☐ Easygoing, Calm	☐ Optimistic	☐ Confident	☐ Takes Risks
☐ Irritable	☐ Pessimistic	☐ Expects Failure	☐ Cautious
☐ Hardworking	☐ Caring	☐ Sharing	☐ Generally Happy
☐ Lazy	☐ Uncaring	☐ Selfish	☐ Generally Unhappy

PROBLEM BEHAVIORS

• Please check any of the behaviors which occur excessively or frequently now and/or in the past.

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☐ Odd Behavior	☐ Argues	☐ Distractible	☐ Withdrawn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

For Clinician's Use.____

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

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• 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. ______________________________

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

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

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• 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	____________	______	☐	☐	☐	☐	☐	☐
1	____________	______	☐	☐	☐	☐	☐	☐
2	____________	______	☐	☐	☐	☐	☐	☐
3	____________	______	☐	☐	☐	☐	☐	☐
4	____________	______	☐	☐	☐	☐	☐	☐
5	____________	______	☐	☐	☐	☐	☐	☐
6	____________	______	☐	☐	☐	☐	☐	☐
7	____________	______	☐	☐	☐	☐	☐	☐
8	____________	______	☐	☐	☐	☐	☐	☐
9	____________	______	☐	☐	☐	☐	☐	☐
10	____________	______	☐	☐	☐	☐	☐	☐
11	____________	______	☐	☐	☐	☐	☐	☐
12	____________	______	☐	☐	☐	☐	☐	☐
	____________	______	☐	☐	☐	☐	☐	☐
	____________	______	☐	☐	☐	☐	☐	☐
	____________	______	☐	☐	☐	☐	☐	☐

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 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 ☐ DUIL/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
☐ Change of residence	______	☐ Family gambling problems	______
☐ Change of schools	______	☐ Family psychiatric problems	______
☐ Change of custody	______	☐ Family chronic illness	______
☐ Marital conflict	______	☐ Other family problems	______
☐ Parents separated	______	☐ Rejection by family member(s)	______
☐ Parents divorced	______	☐ Abuse to self (verbal, physical, sexual)	______
☐ Parent visitation problems	______	☐ Witnessed abuse to others	______
☐ Post divorce parent conflict	______	☐ Victim of abuse	______
☐ Parent(s) remarried	______	☐ Suffered/Witnessed significant accident or injury	______
☐ Step parent problems	______	☐ Other severe fright or trauma	______
☐ Sibling birth	______	☐ Death of family member or friend	______
☐ Acquired step sibling(s)	______	☐ Suicide of family member or friend	______
☐ Family economic problems	______	☐ Death or pet	______
☐ Family job problems	______	☐ Other_____________________	_______
☐ 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	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Other Relatives	☐	☐	☐	☐	☐	☐

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	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐
Other Relatives	☐	☐	☐	☐	☐

- 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.**

☐ Vision Problems
☐ Hearing Problems
☐ Gross Motor Coordination Problems
☐ Fine Motor Coordination Problems
☐ Cerebral Palsy
☐ Seizure Disorder
☐ History or Feb rile Seizures
☐ History of Meningitis
☐ History of Encephalitis
☐ Cardiac Problems
☐ Diabetes
☐ Sickle Cell Disease
☐ Genetic Disorder
☐ Asthma
☐ Allergies
☐ Chronic Ear Infections
☐ Tics (Twitches)
☐ Significant Weight Loss
☐ Significant Weight Gain
☐ Frequent Vomiting
☐ Frequent Headaches
☐ History of Migraines
☐ Frequent Stomach Aches
☐ Frequently Ill
☐ Loss of Menstruation (Amenorrhea)
☐ Failure to thrive or growth retardation
☐ 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

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- 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