

Child and Adolescent History Form

The information requested in this form will be treated as CONFIDENTIAL, unless by law I am required to provide it. The questions are designed to help me understand your concerns about your child or adolescent, so that I may be able to assist you. If you have any questions about the requested information, please do not hesitate to ask me. *Please note that, unless required by law or professional guidelines, I will obtain written permission from you (in the case of a minor child) and your child to contact any professionals noted on this form.*

Child/Adolescent's Name: _____

Address: _____ Zip Code: _____

Birth date: _____ Age: _____ Grade: _____

Father's Name: _____

Age: _____ Education: _____ Occupation: _____

Phone: Home: () _____ Work: () _____

Cell Phone () _____ Please the best phone for me to use.

Email _____

Mother's Name: _____

Age: _____ Education: _____ Occupation: _____

Phone: Home: () _____ Work: () _____

Cell Phone () _____ Please the best phone for me to use.

Email _____

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 .

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? _____

• Does the non-custodial parent:

Aware that Therapy is being sought 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.

- 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/Oppositional 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

• 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 12).

For Clinician Use _____

BIRTH TO FIVE YEAR DEVELOPMENTAL HISTORY

• Mother’s Pregnancy Normal Complicated [Explain] _____

• Check any substances the biologic mother used during her pregnancy and detail 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 -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 educations did he/she receive? _____

• Please write in the school or district (i.e., city, township, different state) attended by your child/adolescent for each grade, and the *typical grades* 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 or below.

Grade	School District	Academic Grades	Learning Probs	Peer Probs	Short Attn 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"/>

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.

_____ Hrs/week

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 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.

• 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.

Please include age when event occurred.

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 of 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 NAME

Outpatient Psychiatric/Psychotherapy/Counseling _____

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]

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

- Is your child/adolescent currently taking any medication(s)? No Yes If Yes, please list name of medications and daily dosage.

SUBSTANCE ABUSE HISORY (cont'd)

- 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 Parent Foster Parent Guardian Other: _____

Signature of Adult Completing Form Date

Printed Name