Client Name_____

CHILD AND ADOLESCENT HISTORY

Name_____ Date of Birth_____ Age_____ Date_____

Parent(s)_____Custodial parent (If applicable)_____

Physician_____ Referral Source_____

School_____ Grade_____ Teacher_____

I. PRESENTING PROBLEM(S)

What concerns do you have about your child or family?_____

_____

When did the problem(s) start?_____

_____

What incidents led you to come here?_____

_____

What changes in your family have you noticed since this problem began?_____

_____

What would you like to change?_____

_____

Do both parents see the problem the same way?_____

_____

Does the child agree that there is a problem?_____

_____

What major changes have occurred in your family over the past few years (moves, changes in income or employment, changes in family composition)?_____

_____

Have you sought treatment before? Yes_____ No_____

If so, list the therapists and dates of therapy in chronological order. Include any psychological and/or educational reports.

Name of Therapist or Examiner	Therapy or Testing?	Dates Seen
_____		
_____		
_____		

II. FAMILY INFORMATION

MOTHER

Name_____ Age_____

Occupation_____ Religion_____

Describe the relationship between the mother and child/adolescent._____

_____

How does mother discipline the child/adolescent?_____

_____

FATHER

Name_____ Age_____

Occupation_____ Religion_____

Describe the relationship between the father and the child/adolescent._____

_____

How does father discipline the child/adolescent? _____

If either parent lives outside the home, what is the frequency of contact with this parent?

_____

SIBLINGS/PEERS

Describe child/adolescent's relationship with each sibling.

Sibling 1: Name: _____Age:_____

Relationship _____

Sibling 2: Name: _____Age:_____

Relationship _____

Sibling 3: Name: _____Age:_____

Relationship _____

Describe child/adolescent's relationship with peers._____

_____

_____

_____

_____

Below are several problems that sometimes run in families. We are interested in whether anyone in the family *other than this child* has or has had any of these. Please put an X in the column of the family member(s) who have or have had each problem.

FAMILY HISTORY	*Child's Mother*	*Child's Father*	*Child's Brother(s)*	*Child's Sister(s)*	*Others (specify)*
Inattentive/Distractible					
Impulsive/Hyperactive					
Trouble learning to read					
Trouble with arithmetic					
Trouble with writing					
Kept back in school					
Speech problems					
Behavior problems in childhood					
In trouble as a teenager					
Depression					
Anxiety					
Other mental illness					
Drinking problem or drug abuse					
Health Problems (please specify)					

III. DEVELOPMENTAL HISTORY

Any complications during pregnancy/delivery? Describe:_____

_____

Birth Weight:_____

Is child adopted? Y/N At what age?_____

Describe any special circumstances: _____

Walked at:_____months Talked at:_____months

Has child/adolescent ever received speech therapy?_____

Dates:_____

Describe child/adolescent's toilet training._____

_____

List any childhood diseases, serious illnesses, or health problems the child/adolescent has had.

_____

Any present health problems?_____

When was the last time the child/adolescent had a complete physical exam?_____

Results? _____

Eye Exam_____

Hearing Exam_____

What medications is the child/adolescent presently taking and why?_____

_____

Have parents, siblings, or this child/adolescent ever taken medication for psychological reasons?

Yes_____ No_____ Name: _____

Name of family member_____

Name of Doctor_____

What medicine?_____ How long?_____

IV. MEDICAL HISTORY

AREA	*YES*	*NO*	*COMMENTS*
Ear infections			
Tubes in ears			
Concussion			
Head trauma			
Seizures			
Hearing difficulties			
Vision problems			
Eating problems			
Bedwetting			
Daytime Wetting			
Constipation			
Soiling pants			
Speech difficulties			
Chronic illness/complaints			
Stomach problems			
Allergies			
Surgery			
Broken bones			
Sleep difficulties			
Nightmares			
Significant accidents			
Hospitalizations			
History of sexual or physical abuse			
History of verbal abuse			
Smoking			
Other			

V. EDUCATIONAL HISTORY

List schools from pre-school to current placement.

School	Grade(s) Attended	Conduct/Grades

Any evidence of learning disabilities?_____

Any evidence of attentional problems (with/without hyperactivity)?_____

How would current teacher(s) describe your child?_____

What are your child/adolescent's leisure interests?_____

VI. RELIGIOUS HISTORY

In what religion is the child being raised?

Protestant_____ Catholic_____ Jewish_____ Other_____

Does he/she receive religious instruction?

Yes_____ No_____ If so, where?_____

Do you and/or your spouse regularly attend religious services?

Yes_____ No_____ If so, where?_____

VII. OTHER INFORMATION

Describe several of your child/adolescent's strengths:

1. _____
2. _____
3. _____

Please add anything you feel might help in understanding your child/adolescents' problem. Use the back if necessary.