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CHILD AND ADOLESCENT HISTORY FORM

Patient Name: _____ Date of birth: _____

Date form completed: _____ Gender: M F (circle one)

Name of person completing this form: _____

Home Address: _____ Phone: (___) _____

_____

School: _____ Grade: _____

Whom can I thank for referring you? _____

Who is your child's pediatrician? _____

What is it about your child that concerns you? _____

_____

_____

_____

How long has this problem existed? _____ Years Months (circle one)

What have you been told by others regarding your child's difficulties? _____

_____

_____

_____

What can I do to help you and your child? _____

_____

_____

_____

Is your family intact? Yes No (circle one)

Who lives in the home?

Adults

Name	Age	Relationship	Education Level	History of emotional or learning difficulties
1.				
2.				
3.				
4.				

Who lives in the home (continued)?

Children

Name	Age	Relationship	Education Level	History of emotional or learning difficulties
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Mother: Occupation: _____

Health Status: _____

Father : Occupation: _____

Health Status: _____

What languages are spoken in the home? _____

BLENDED, SEPARATED, DIVORCED FAMILIES PLEASE COMPLETE THE FOLLOWING:

When did the divorce/separation occur? _____

_____

What are the custody arrangements? _____

Who is the custodial parent? _____

Where is the non-custodial parent? _____

_____

How often does the child see the non-custodial parent? _____

_____

Mother's marital history

Dates married (From-To)	Spouse's Name	How did the marriage end?
1.		
2.		
3.		

Father's marital history

Dates married (From-To)	Spouse's Name	How did the marriage end?
1.		
2.		
3.		

Mother's children		*Father's children*	
Name	Date of birth	Name	Date of birth
1.			
2.			
3.			
4.			

If not remarried, does mother have a significant other? Yes No

If yes, who? _____

How long? _____

If not remarried, does father have a significant other? Yes No

If yes, who? _____

How long? _____

Developmental and Health History

Was the child from a planned pregnancy? Yes No

Was the child adopted? Yes No How old was the child? _____

Were there any problems during the pregnancy (e.g., toxemia, diabetes, high blood pressure, other)? _____

_____

_____

Were there any problems during delivery? _____

_____

_____

Were there any problems during the first 3 months (e.g., no breathing, feeding, sleeping, other)? _____

_____

_____

Did the child attain developmental milestones at expected ages?

Sat alone _____ Toilet training started _____

Crawled _____ Toilet training finished _____

Stood alone _____ Rode tricycle _____

Walked without holding _____

Which childhood diseases has the child had?

Measles	No	Yes	Age(s) _____
Mumps	No	Yes	Age(s) _____
Chicken Pox	No	Yes	Age(s) _____
Strep Throat	No	Yes	Age(s) _____
Ear Infections	No	Yes	Age(s) _____

Please list present medication(s) and dosages: _____

_____

Has your child had any of the following difficulties? If yes, please explain.

Accidents/Fractures: _____

High fever, unknown cause: _____

Seizures: _____

Food poisoning: _____

Lead ingestion: _____

Bedwetting or soiling: _____

Constipation: _____

Vision problems: _____

Hearing problems: _____

Speech problems: _____

Does the child speak excessively loudly? _____

Memory problems: _____

Allergies: _____

Lyme Disease: _____

Joint Pain: _____

History of Strep: _____

Sleeping difficulties: _____

Head banging: _____

Rocking: _____

Other: _____

Adolescent Issues
(12-18 years old)

Have menses begun?	No	Yes	N/A	Age of onset _____
Does he/she date?	No	Yes		
Is he/she sexually active?	No	Yes	Don't know	
Has she been pregnant?	No	Yes	If yes, what was the outcome? _____	
Does he/she drive?	No	Yes		
Does he/she work?	No	Yes	Where _____	
			How many hours/week? _____	

Extracurricular activities? _____

_____

Does he/she have a group of close friends? No Yes

How does he/she relate to authority? _____

Does he/she use: Drugs	No	Yes	
Alcohol	No	Yes	
Tobacco	No	Yes	

Has he/she ever run away? No Yes

If yes, when? _____

Where to? _____

For how long? _____

Has he/she ever been hospitalized for emotional problems? No Yes

If yes, under what circumstances? _____

_____

_____

Has he/she ever been suspended or expelled from school? No Yes

If yes, when? _____

Why? _____

Any legal problems? No Yes

If yes, under what circumstances? _____

_____

_____

Any suicidal talk, gestures, or attempts? No Yes

Describe _____

_____

_____

Academic History

List schools that the child has attended:

Name of school	City	State	Grade(s)	Problems

Has your child ever been retained? No Yes

Has your child ever been tested (psychological, neuropsychological, educational)? No Yes

Please list below any previous evaluations:

Place of evaluation	Type	Address	Date

Has your child ever been in a special class placement, received remedial help, or had tutoring? No Yes

If yes, please specify: _____

_____

_____

Relationship with teacher(s): Excellent Average Poor

Relationship with peers: Excellent Average Poor

Is there any history (diagnosed or undiagnosed) of mental, emotional, or psychiatric problems in your family (e.g., anxiety, OCD, depression, ADHD, mood disorders, bipolar disorder, schizophrenia, substance abuse, or neurological problems)?

No Yes

If yes, please explain: _____

PLEASE BRING COPIES OF ALL PSYCHOLOGICAL, EDUCATIONAL OR OTHER EVALUATIONS TO THE NEXT APPOINTMENT

Activities

What things does your child like to do? _____

What things does your child do well? _____

What things present difficulty for your child? _____

Does your child recognize dangerous situations? No Yes

Please give a detailed description of an average day: _____

Other comments: _____

Symptoms and Behaviors Checklist

Please answer every question, even if the response is "no." Indicate the severity of the symptom, if known, for the past year.

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Depression				
Tearfulness				
Feeling Lonely				
Feeling Sad				
Withdrawn				
Spending more time alone				
Moody				
Avoiding friends				
Weight Change				
Eating more/Excessive Appetite				
Eating less/Loss of Appetite				
Binge Eating				
More exercise				
Less exercise				
Decreased interest in usual activities				
Difficulty Falling Asleep				
Tired				
Sleeping more				
Sleeping less				
Waking during the night				
Trouble Getting Out Of Bed				
Sleepwalking				
Nightmares/bad dreams				
Headaches				
Careless about dress/hygiene				
Trouble concentrating				
Trouble Sitting Still				
Distractible				
Impulsive				
Disorganized				
Hearing things others don't hear				
Seeing things others don't see				
Trouble following directions				
Perfectionistic/Overly Rigid				

SYMPTOM	SEVERITY			
	NO	MILD	MODERATE	SEVERE
Anxious				
Worrying				
Rigid (re: transitions, routines)				
Concerned about injury/bodily harm				
Feeling panicky				
Obsessive/ritualistic behaviors				
Critical of others				
Have few friends				
Low self-esteem				
Disappointed in appearance				
Disappointed in achievements				
Disappointed in social life				
Legal problems/Ever Been Arrested				
Runs Away From Home				
Defiant				
Arguing				
Trouble Controlling Aggression				
Destroying/damaging property				
Irritable				
Angry				
Easily frustrated				
Giving away belongings				
Threats to oneself				
Wishes to be dead				
Suicidal thoughts				
Suicidal intent				
History of self-injurious behavior				
Homicidal thoughts				
Has Been Sexually Abused				
Sexually Molests Other Children				

Additional Comments: _____