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Child/Adolescent History Form

Today's Date: _____

Child's Name: _____
Street Address: _____
City/State/Zip: _____
Date of Birth: _____ Age: _____ Religion: _____
Race/Ethnicity: _____
Language(s) spoken at home: _____
If more than one, what is the primary language spoken at home: _____
Place of birth: _____

Mother:
Name: _____ D.O.B.: _____
Address (if different): _____
_____
Home Phone: _____ Work: _____ Mobile: _____
Education: High School: _____ If graduated, year:
College: _____ If graduated, year and degree:
Graduate degree: _____ If graduated, year and degree:
Occupation: _____ Place of Business: _____
Religion: _____ Ethnicity: _____
Relationship to Child: □ Biological parent □ Adoptive parent □ Other _____

Father:
Name: _____ D.O.B.: _____
Address (if different): _____
Home Phone: _____ Work: _____ Mobile: _____
Education: High School: _____ If graduated, year:
College: _____ If graduated, year and degree:
Graduate degree: _____ If graduated, year and degree:
Occupation: _____ Place of Business: _____
Religion: _____ Ethnicity: _____
Relationship to Child: □ Biological parent □ Adoptive parent □ Other _____

If parents are married: Date of marriage: _____

If not, parents are: □ Separated Date of separation:_____
□ Divorced Date of divorce:_____
□ Deceased □ mother Date: _____
□ father Date: _____
□ Never married

If adopted or in foster care, child was with biological parents until age _____

Who has legal guardianship for the child: □ Mother & Father
□ Mother □ Father □ Other:_____

Who has authority to make medical decisions for the child? □ Mother & Father
□ Mother □ Father □ Other:_____

Please list the names along with ages & relationships to the child of any people residing at home:

_____
_____
_____
_____

CHIEF CONCERNS

Please describe the reasons you are seeking this consultation. Please include when problems started and how the child is functioning at home, at school, and with peers.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Medical Care:

Primary Care Doctor/Pediatrician: _____ Phone #: _____
Primary Care Doctor Address _____

Current and Past Mental Health Professional(s) (please list Names and phone numbers):

_____
_____
_____
_____

Has your child ever been diagnosed with a psychiatric disorder or learning disorder? If so, please list the disorders and at what age they were first diagnosed.

_____
_____
_____
_____

Does your child have any medical problems? If so, please list the conditions and at what age they first presented.

_____
_____
_____
_____

Has your child ever been hospitalized? Please give place, dates, and reasons.

_____
_____
_____

Has your child ever been brought to an emergency room? Please give place, dates, and reasons.

_____
_____
_____

Has your child ever had surgeries? Please give place, dates, and reasons.

_____
_____
_____
_____

Drug Allergies? (List any medicines your child is allergic to) NONE KNOWN _____

_____

Current Medications: List all medicines your child is currently taking, both psychiatric and other, & include dosages of medication & reason for which medication is prescribed: NONE _____

_____
_____
_____
_____

Past Medications, including dosages of medication & reasons for which medication was prescribed: NONE _____

_____
_____
_____
_____

SCHOOL HISTORY

Current School: _____ Grade: _____
Address: _____
_____
Telephone: _____

Type of Program: ___Public ___ Private
___Regular Ed ___Special Ed (specify type) _____
If applicable, please check boxes next to special services that your child receives:
___ Not applicable ___Resource Room ___ Speech/Language Therapy
___ Occupational Therapy ___ Physical Therapy ___ Counseling
___ 1:1 Para ___ Other _____

School Personnel involved with child:
Teacher _____ Phone_____
Teacher _____ Phone _____
Guidance Counselor _____ Phone _____
School Psychologist _____ Phone _____

Please list the schools your child has attended, including their location & dates or ages at which your child attended these schools.

Did your child experience any difficulties starting school?

_____
_____

Were any learning difficulties identified? (and in what grade?)_____
_____

Were any grades repeated? _____

_____

_____

Has your child had special tutoring outside of school? _____

_____

_____

How many times per week does your child see friends outside of school? _____

_____

_____

How does your child get along with other children? _____

_____

_____

What activities does your child enjoy? _____

_____

_____

List your child's talents, special abilities, and strengths: _____

_____

_____

Does your child belong to any groups, teams or organizations? _____

_____

_____

Does your child take any lessons other than academics (music, dance, martial arts, sports, etc.)?

_____

_____

_____

CHILD CARE AND AFTER-SCHOOL PROGRAMS

Does your child receive care from a:

Child care provider at home?	No __ Yes __ Who: _____ Hours _____
Child care provider in someone else's home?	No __ Yes __ Who: _____ Hours _____
A day care center?	No __ Yes __ Who: _____ Hours _____
An after school program?	No __ Yes __ Who: _____ Hours _____

DEVELOPMENTAL HISTORY

Birth and Newborn Period:

Duration of Pregnancy (in weeks): _____

Did mother experience any of the following during pregnancy?
___ Spotting or Vaginal Bleeding ___ Threatened Miscarriage ____ Diabetes
____ Preeclampsia ____ Toxemia ___ Kidney Disease _____ Flu or Virus
____ Accident or Injury ____ Took Any Prescription Drug _____ Emotional Problems
____ Family Problems _____ Alcohol Use _____ Drug Use

How long was the mother's labor? Were there any complications or problems during labor?
_____
_____
_____

Was the baby delivered by vaginal delivery or C-section? Were there any complications or problems during delivery?
_____
_____
_____

How long was the baby in the hospital after he/she was born? _____

What was the baby's weight at birth? _____

Were there any complications during the newborn period? (e.g. did the baby need to be in the NICU, or did the baby require oxygen or breathing support? Did the baby have any signs of infection or jaundice that required treatment?)
_____
_____
_____

How would you describe your child's temperament and behavior as an infant? Did your child have colic? Did your child have any problems eating or sleeping? Did your child make good eye contact as an infant?
_____
_____
_____
_____
_____
_____
_____

Developmental Milestones: Please indicate at what age your child achieved the following milestones in their development. If you cannot recall the exact age, please note if you recall them achieving these milestones at the normal expected age or early or late. If they have not yet achieved this milestone, please indicate "not yet."

MOTOR

Held head up _____ Sat without help _____

Crawled _____ Stood _____

Walked without help _____ Ran _____

Rode a tricycle _____ Tied shoes _____

Fed self _____ Dressed Self _____

TOILETING

Dry during the day _____ Dry at night _____

Bowel Control _____

LANGUAGE

Babbling _____ First Word _____

Named objects _____ Put 2 words together _____

Has your child shown adult sexual body development (puberty)? Yes / No
If so, at what age did this start? _____

For females, has your child started menstruating? Yes / No
If yes, at what age did this start? _____
Has she had any problems with menstruation (irregular periods, pain, mood changes)?
_____
_____

Have you ever had any concerns that your child has been a victim of physical or sexual abuse, or neglect? Please comment on if Child Protective Services has ever been involved in your child's care.
_____
_____
_____

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please indicate if there is any history of any of the following medical or psychiatric disorders in your child's parents, siblings, grandparents, or other relatives. Please indicate which relative(s) suffer from this condition & if they have received any effective treatment.

PSYCHIATRIC DISORDERS
Depression _____
Bipolar Disorder _____
Schizophrenia _____
Anxiety Disorder _____
Obsessive Compulsive Disorder _____
Post Traumatic Stress Disorder _____
Autism Spectrum Disorder/Aspergers_____
ADD/ADHD_____
Learning Difficulties_____
Alcohol abuse_____
Drug abuse _____
Personality Disorder _____
Mental Retardation _____
Other_____

MEDICAL ILLNESSES
Heart attack or sudden cardiac death _____
Heart murmurs_____
Fainting/syncope _____
Arrythymia (abnormal heart rhythym) _____
High blood pressure _____
Diabetes _____
Thyroid problems _____
Obesity _____
Crohn's Disease or Ulcerative Colitis _____
Irritable Bowel Syndrome _____
Reflux/GERD_____
Cancer _____
Asthma _____
Headaches/migraines_____
Seizures _____
Tics _____
Head Trauma _____
Other _____