CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

The purpose of this questionnaire is to obtain an understanding of your child's life experience and background. Then we can begin to develop a comprehensive treatment program suited to your specific needs. Please return this questionnaire at your first scheduled appointment.

Child/Adolescent's Name: _____ Circle: M /F

Today's Date: _____ Date of Birth: _____ Age: _____

Parent/Guardian's Name: _____DOB:_____
Address: _____Phone Number: _____
Cell Number: _____ Work Number: _____

Parent/Guardian's Name: _____ DOB: _____
Address: _____Phone Number: _____
Cell Number: _____ Work Number: _____

Step-Parent's Name: _____DOB:_____
Address: _____Phone Number: _____
Cell Number: _____ Work Number: _____

Step-Parent's Name: _____DOB:_____
Address: _____Phone Number: _____
Cell Number: _____ Work Number: _____

Language(s) spoken at home: _____

Who referred you? _____

PRESENTING PROBLEM: (What is your main concern/worry?)
_____
_____
How long have these problems occurred? (Number of weeks, months, years)?
_____

What made you seek help at this time?
_____
Problems perceived to be: _____very serious _____serious _____slightly serious
What changes would you like to see in your child?
_____
_____
What changes would you like to see in your family?
_____

_____

SCHOOL INFORMATION

Name of School _____ City or District_____

Grade Level _____

Current Grades: __ Failing __ Below Average __ Average __ Above Average

Grade(s) Repeated: _____

Special Education: ___ Yes ___No __ Speech/Language __Intellectual Disability __ Learning Disabilities __ Emotionally Disturbed __Autism __Other Health Impaired

Problems at school:

_____

Schools Attended:

_____Grade:_____

_____Grade:_____

_____Grade:_____

_____Grade:_____

_____Grade:_____

_____Grade:_____

COUNSELING AND/OR PSYCHIATRIC INPATIENT/OUTPATIENT HISTORY

Name of Clinic/Counselor/Therapist	Date Began/Ended	Helpful? Yes/No

Inpatient Psychiatric History

Name of Facility or Psychiatric Hospital	Date Began/Ended	Helpful? Yes/No

MEDICAL HISTORY

Primary Care Physician: _____ Phone Number _____

Date of Last Physical Exam: _____

Please check if you child has ever had any of the following Medical problems:

___ Allergies ___ Fainting ___ Vision Problems ___ Hearing Problems ___ Skin Problems
___ Eating Problems ___ Stomach Problems ___ Dental Problems ___ Anemia
___ Epilepsy/Seizures ___ Soils/Wets ___ Asthma ___ Infectious Disease
___ Accident Prone ___ Anemia/Fatigue ___ Head Injury ___ Heart Problems
___ Other: _____

Has the child ever been hospitalized or had any surgeries? Please list below:

_____
_____
_____
_____
_____
_____

Past/Current Mental Health Diagnosis (if applicable)

___ADHD/ADD ___Depression ____Anxiety ____Bipolar _____Substance Abuse _____ Other

Is the child currently prescribed medication? ____Yes ____No

Please list below all medications your child is presently taking and the condition for which they are prescribed.

Condition	Medication	Dosage	Times Per Day	Prescribing Doctor

DEVELOPMENTAL HISTOR Y

Pre-Natal: Normal Pregnancy ___ Yes ___ No If no, please explain:

_____

Normal Birth ___ Yes ___ No If no, please explain:

_____

Please mark if your child has/had problems in the following areas:

___ Walking/General Motor Development
___ Toilet Training
___ Speech/Language
___ Early Social Development

___ Other Please explain:

_____

PROBLEM BEHAVIORS

Please mark if your child or adolescent is demonstrating any of the following behaviors:

_____Very unhappy _____Irritable _____Screams/Yells _____Withdrawn
_____Daydreaming _____Fearful _____Clumsy _____Overactive
_____Low Self-esteem _____Short Attention _____ Distractible _____ Lacking initiative
_____ Distractible _____Lacks motivation _____ Stubborn _____ Phobic
_____ Peer Conflict _____ Impulsive _____ Destructive _____ Mean to Others
_____ Fire Setting _____ Head Banging _____ Lying _____ Rocking
_____ Poor Grades _____ Conflict w/Others _____ Truancy _____ Sexual Trouble
_____ Eating Problems _____ Suicidal Ideations _____ Drug/Alcohol _____ Stealing
_____ Bed Wetting _____ Soiling Pants _____ Shy _____ Sleeping Problems
_____ Self-Mutilating _____ Nightmares _____ Anxious/Tense _____ Worries a lot
_____ Cries Easily _____ Fearful _____ Strange Behavior _____ Fights/Hits/Kicks
_____ Hurts Animals _____ Throws Things _____ Other

FAMILY HISTORY

___ Family History of Suicide ___ Family History of Abuse/Neglect
Explain: _____
Explain: _____
Family History of Mental Health Problems ___ Family History of Legal Issues
Explain: _____
Explain: _____
___ Family History of Medical Problems ___ Family History of Substance Abuse
Explain: _____
Explain: _____

LIVING ARRANGEMENTS

Who lives at home with child/adolescent?

_____
_____
_____
_____

Was the child ever placed, boarded, or lived away from the family? ____Yes ____No Explain:

_____
_____

Name of sibling(s)	Age	Grade Level
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL/FAMILY RELATIONS

How does your child/adolescent get along with same-age peers?
Excellent Good Average Fair Poor
Describe:

_____

How does your child/adolescent get along with siblings?
Excellent Good Average Fair Poor
Describe:

_____

How does your child/adolescent get along with caretakers?
Excellent Good Average Fair Poor
Describe: _____

STRENGTHS

What are (3) of your Child/Adolescent's STRENGTHS?
1- _____
2- _____
3- _____

What are (3) of your Family's STRENGTHS?
1-

_____

_____
2- _____
3- _____

List any other concerns or information that the doctor should know about?

_____

_____

Thank you for taking the time to complete this form.
Please bring this with you to your first appointment.