Child/Adolescent Personal Information

The purpose of this form is to obtain a detailed understanding of your child's growth and development. Please answer all of the questions below, to the best of your ability. If a question does not apply to your particular situation, write, N/A.

IDENTIFYING INFORMATION

Child's name: _____ Today's date: _____

Child's date of birth: _____ Child's age: _____ Sex: Male ____ Female ____

Home address: _____

_____

Home phone number: _____

PRESENTING PROBLEM

Why are you seeking this evaluation or treatment? _____

_____

When did these problems begin? _____

What are your goals for this evaluation or treatment? _____

_____

_____

PARENTS, SIBLINGS, AND OTHERS IN HOME

Mother's name: _____ Mother's age: _____

Address: _____

Home phone: _____ Work phone: _____

Occupation: _____ (Full-time/part time?)

Education/highest grade completed: _____

Father's name: _____ Father's age: _____

Address (if different from above): _____

Home phone: _____ Work phone: _____

Occupation: _____ (Full-time/part time?)

Education/highest grade completed: _____

(cont.)

Does your child have stepparents? No ____ Yes ____

If yes, please complete the following information:

Name(s): _____

Relationship(s) to child: _____

Address(es)/phone(s): _____

_____

Is the child adopted or being raised by persons other than his/her biological parents? No ____ Yes ____

If yes, explain: _____

Name of sibling	Age	Gender	Lives at home?	Nature of relationship with child?
1. _____	____	____	_____	_____
2. _____	____	____	_____	_____
3. _____	____	____	_____	_____

Please list any others living in the household:

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

FAMILY CIRCUMSTANCES

Who cares for the child when parents or caregivers are at work or gone? _____

With whom does the child currently live? _____

Are the parents divorced or separated? No ____ Yes ____

If yes, who has custody? _____

How often does the noncustodial parent see the child? _____

Family's religious affiliation (optional): _____

How frequently does this child see her/his grandparents? _____

Has the family recently experienced any unusual or stressful events? No ____ Yes ____

If yes, explain: _____

PREGNANCY

Did the mother receive prenatal medical care? No ____ Yes ____

If yes, what kind? _____

Length of pregnancy: _____

Did the mother experience any emotional or medical difficulties during the pregnancy? No ____ Yes ____

If yes, explain: _____

Length of labor: ____ hours Apgar scores: _____

Birth weight: ____ lbs. ____ oz. Length: ____ inches

(cont.)

DEVELOPMENT

Was this child breast-fed or bottle-fed? _____ Age weaned: _____

Did the child experience any of the following problems during infancy or toddlerhood? If yes, please explain.

Colic	No ___ Yes ___
Excessive crying	No ___ Yes ___
Delayed language development	No ___ Yes ___
Unclear speech	No ___ Yes ___
Eating problems	No ___ Yes ___
Delayed fine motor skills	No ___ Yes ___
Delayed gross motor skills	No ___ Yes ___

At what approximate age did your child begin exhibiting the following behaviors?

Crawled: _____ Sat alone: _____

Walked independently: _____ Spoke first words: _____

Spoke in sentences: _____ Was toilet trained: _____

For an adolescent, please indicate the following:

Age at onset of puberty: _____ Age at first menstruation (for a girl): _____

Which hand does your child use for writing? _____ Eating? _____

Throwing? _____ Other? _____

Has your child been the victim of abuse? No ___ Yes ___

If yes, please explain: _____

MEDICAL AND PSYCHIATRIC HISTORY

Name of child's primary care physician: _____

Address: _____

_____

Phone: _____

Date of most recent physical exam: _____ Results: _____

Date of most recent dental exam: _____ Results: _____

Date of most recent vision exam: _____ Results: _____

Date of most recent hearing exam: _____ Results: _____

Has the child experienced any of the following medical problems? If yes, please explain.

Frequent colds	No ___ Yes ___
Frequent ear infections	No ___ Yes ___
Asthma	No ___ Yes ___
Gastrointestinal problems	No ___ Yes ___
Muscle pain	No ___ Yes ___
Skin problems	No ___ Yes ___
Repetitive behaviors (head banging, rocking, etc.)	No ___ Yes ___
Allergies	No ___ Yes ___

(cont.)

Vision problems No ___ Yes ___
Does your child wear glasses? No ___ Yes ___
Hearing problems No ___ Yes ___
Cerebral palsy No ___ Yes ___
Lead poisoning No ___ Yes ___
Seizures No ___ Yes ___
Congenital problems No ___ Yes ___
Please list any other health concerns: _____

Medication

Is your child currently taking any kind of medication? No ___ Yes ___
If yes, indicate name, dose, and reason for medication: _____
Is your child experiencing any side effects from the medication(s)? _____

Alcohol or Drug Use

Does your child use alcohol or drugs? No ___ Yes ___
If yes, explain: _____

Previous Evaluations

Has your child ever had any of the following evaluations? If yes, please indicate name of examiner, date of examination, and reason for exam.

Psychological or psychiatric evaluation: No ___ Yes ___
If yes, name of evaluator: _____ Date of valuation: _____
Reason for evaluation: _____
Neuropsychological evaluation: No ___ Yes ___
If yes, name of evaluator: _____ Date of valuation: _____
Reason for evaluation: _____
Neurological evaluation: No ___ Yes ___
If yes, name of evaluator: _____ Date of valuation: _____
Reason for evaluation: _____

Treatment History

Has your child ever received counseling or psychiatric treatment? No ___ Yes ___
If yes, indicate dates, name of treating professional, reason for treatment, and effectiveness of treatment: _____
_____
_____

Family's Health

Mother's present health: _____
Father's present health: _____
Has anyone in your family experienced a mental, psychological, or academic problem, such as mental retardation, learning disabilities, schizophrenia, depression, epilepsy, or a bipolar disorder? No ___ Yes ___
If yes, explain: _____

(cont.)

SOCIAL HISTORY

How does your child relate to other children? _____

Does your child prefer to play with younger or older children? No ____ Yes ____

If yes, indicate which (younger or older) and explain: _____

Does your child have a best friend? No ____ Yes ____

How many friends does your child have? _____

RECREATIONAL INTERESTS

Does your child participate in sports or recreational activities outside of school? No ____ Yes ____

If yes, describe: _____

What does your child like to do in his/her free time? _____

_____

Have the child's interests in these activities changed recently? No ____ Yes ____

If yes, please explain: _____

What are your family's favorite activities? _____

BEHAVIORAL SYMPTOMS

Does your child have difficulty with any of the following problems? If yes, please explain.

Has trouble meeting new people; is shy or withdrawn	No ____ Yes ____
Is overly anxious	No ____ Yes ____
Seems sad or depressed	No ____ Yes ____
Has thought of suicide	No ____ Yes ____
Refuses to comply with adults' requests or violates parental rules	No ____ Yes ____
Has conduct problems	No ____ Yes ____
Is physically cruel to other people or animals	No ____ Yes ____
Is inattentive	No ____ Yes ____
Problems concentrating	No ____ Yes ____
Is restless	No ____ Yes ____
Makes careless mistakes	No ____ Yes ____
Has trouble playing quietly	No ____ Yes ____
Has frequent mood shifts	No ____ Yes ____
Frustrates easily	No ____ Yes ____
Has difficulty managing anger	No ____ Yes ____
Has eating problems	No ____ Yes ____
Has fears/phobias	No ____ Yes ____
Has hallucinations	No ____ Yes ____
Has experienced trauma	No ____ Yes ____

Has your child ever experienced difficulty with the law? No ____ Yes ____

If yes, explain: _____

(cont.)

EDUCATIONAL STATUS AND HISTORY

Current Status

Name of current school: _____ Grade: _____

Type of school: Private ____ Public ____ Home-schooled ____ Other _____

Teacher(s): _____

School address: _____

_____

School phone number: _____

Does your child currently receive any special education services? No ____ Yes ____

If yes, please specify: _____

What grades does the child currently receive? _____

Is this a change from previous years? No ____ Yes ____

If yes, explain: _____

School History

Preschool: At what age? _____ For how many days/hours? _____

Any problems? No ____ Yes ____ If yes, describe: _____

Did the child have difficulty or receive any special education services in any of the following grades? If so, please explain.

Kindergarten	No ____ Yes ____
Grades 1–3	No ____ Yes ____
Grades 4–6	No ____ Yes ____
Grades 7–8	No ____ Yes ____
High school	No ____ Yes ____

Does your child dislike going to school? No ____ Yes ____

If yes, why? _____

What are your child's favorite subjects? _____

What are your child's least favorite subjects? _____

What is your child's approach to her/his schoolwork (disorganized/organized, irresponsible/responsible, etc.)? _____

_____

WORK HISTORY

Does your child have a job, or is your child involved in a vocational program? No ____ Yes ____

If yes, who is the child's current employer? _____

Child's position: _____ Hours worked per week: _____

_____