



CHILD AND ADOLESCENT HISTORY

DEMOGRAPHICS

CHILD'S
NAME _____ **AGE** _____ **BIRTHDATE** _____ **M** **F** _____

ADDRESS _____ **PHONE** _____

(home) _____

(work) _____

PARENT/GUARDIAN
(s) _____

REFERRED
BY _____
Name Address Phone

NAME OF PERSON COMPLETING THIS
FORM _____

PRESENTING PROBLEM

Why are you seeking treatment?

When did these problems begin?

What seems to help?

What makes it worse?

Has your child received evaluation or treatment for these problems before? _____ If so, when and with whom?

Other experience in therapy (when, where, who)

Previous history with a Psychiatrist (when where, who)

Child's Strengths _____

Child's Weaknesses _____

Learning/Communication Barriers (speech, hearing, vision, comprehension) _____

Any ethnic, religious, cultural, social issues that may interfere with treatment _____

What are your expectations in coming for treatment _____

PRESENTING BEHAVIORS check all that apply

- lying stealing impulsive defiant oppositional temper outbursts mood swings
- destructive aggressive/assaultive self-mutilates sexual acting out anxious shy sad
- depressed withdrawn poor self esteem social problems overly sensitive overly dependent
- negative hyperactive poor attention span academic problems extreme fears/phobias

(Explain) _____

List any sleep/appetite/eating disturbances _____

List any habits/obsessions/compulsions _____

Suicidal thoughts/plans/gestures (explain) _____

FAMILY HISTORY List family members

NAME	AGE/SEX	RELATIONSHIP TO CHILD	LIVING IN HOME If not, where?	EDUCATIONAL LEVEL	OCCUPATION	EMPLOYED? WHERE?
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Parents married _____ # of years Parents divorced _____ # of years Parents separated _____

Parents remarried? _____

Custody/Visitation arrangements _____

Is this child adopted? _____ If so, how long has the child been in the home _____ Has this been discussed _____

Other child care providers _____

Who does most of the disciplining and what method? _____

Child's response _____

LIFE EVENTS AND CHLD'S AGE

- SCHOOL CHANGES _____
- MOVES _____
- LONG TERM ILLNESS IN FAMILY _____
- DEATH OF PEER/FAMILY MEMBER _____
- MARRIAGE PROBLEMS _____
- PHYSICAL/EMOTIONAL/SEXUAL ABUSE _____
- HISTORY OF MENTAL/EMOTIONAL ILLNESS IN FAMILY _____

DEVELOPMENTAL HISTORY

Problems during the pregnancy, labor, delivery, birth _____

Use of alcohol/tobacco/drugs during pregnancy _____

Birth Weight _____ # in birth order in family _____ Developmental delays? _____

At what age did your child do the following: crawl ____ walk ____ say single words ____ feed self ____ toilet train ____

Current bowel/bladder problems _____

Compared to other children, do you feel that your child has been slower in learning the following (check all that apply):

talking understanding building with blocks, puzzles, drawing pictures naming colors, saying ABC's
 walking, hopping, riding a bike, etc. using buttons, zippers, drawing, etc. sitting still for TV or stories
 playing or socializing with other children

Please explain: _____

Describe interactions with peers:

Preschool _____
 Elementary _____
 Junior High _____
 High School _____

Does your child have difficulty separating (explain) _____

NUTRITIONAL STATUS

DOES YOUR CHILD	NEVER	SELDOM	USUALLY	ALWAYS	COMMENTS
EAT THREE MEALS A DAY?	___	___	___	___	
DRINK SODA/CAFFEINE	___	___	___	___	
EAT JUNK FOOD	___	___	___	___	
EAT FOOD HIGH IN SUGAR	___	___	___	___	
WITHHOLD FOOD TO LOSE WEIGHT	___	___	___	___	
USE LAXATIVES OR DIET PILLS	___	___	___	___	

Do you believe your child has an eating disorder? (If so, please explain) _____

Recent significant weight gain/loss _____

MEDICAL HISTORY

HEIGHT _____ WEIGHT _____ ALLERGIES _____ immunizations current? _____

Family Physician _____
 NAME ADDRESS PHONE

CURRENT PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS

NAME	DOSE	START DATE	REASON	RESPONSE

MEDICATION HISTORY

NAME	DOSE	START/STOP DATE	REASON	RESPONSE

PAST HEALTH/MEDICAL PROBLEMS (surgeries, hospitalizations, injuries, or any chronic conditions) _____

Recent testing/results (labs, EEG, MRI, etc.) _____

Are there any current medical concerns? _____

Is your child sexually active?

Is there any history of drug or alcohol use/abuse?
Treatment? (where, when, explain) _____

SOCIAL HISTORY

Who does your child spend time with _____

Does he/she have difficulty making/keeping friends? (explain) _____

Interests (activities, sports, clubs, etc) _____

EDUCATIONAL HISTORY

Current
School _____ Grade _____ Contact _____
Address _____ Phone _____

Repeated Grades _____ Grades are: ___Average ___Below Average ___Above Average

Special Classes (SBH, LD, DH,

IEP) _____

Special Services received (speech and language, occupational or physical therapy, tutoring,

other) _____

Problems reported (behavior, attention, interruption, social

skills) _____

Recent decline in grades? (explain) _____ Difficult subjects _____

Psychological Testing (when, where,

results) _____

Please list any family members with learning problems or school-related problems (who, what type of problem) _____

EMPLOYMENT

Present employment _____ Date of hire _____ Hours/week _____

Problems or

concerns? _____

Previous

employment? _____

LEGAL

Current legal charges? _____

Court date pending? _____ Probation officer _____

	Name	Phone
Probation History? _____	House Arrest _____	

Juvenile Detention? (when, why, how long) _____

Any other family members with legal charges, legal difficulties or arrest history?

Is there any thing else about your child that you would like us to know? _____

Thank you for completing this form. We look forward to working with you and your child.

Dr. Staci Friedman and Dr. Abby Goldstein
Apple Psychological Associates.