# Child and Adolescent History Form

**CONFIDENTIALITY**
All of the information that you provide in this form is strictly confidential. It cannot be released to anyone without your specific written permission.

**REQUEST FOR OTHER INFORMATION**
In addition to completing this lengthy but important form, please provide us with copies of all previous evaluations, reports, psychological testing, and medical records you have available. Please submit with your paperwork or request to have them sent to us.

**PERSON COMPLETING FORM** ____________________________________________**TODAY'S DATE**___________________
Relationship to child _________________________________

**CHILD INFORMATION**
Full Name __________________________________Date of Birth __________Age___________Sex____

**REFERRAL SOURCE**
Name ______________________________________ (for first two choices below)
Type: Please describe how your referral to us came about.

- ⑨ Primary Care Physician ___________________________________________________
- ⑨ Other Mental Health Provider ___________________________________________________
- ⑨ Self ___________________________________________________
- ⑨ Friend ___________________________________________________
- ⑨ Other _______________

**HOME SITUATION**

**Child primarily lives with:**

- ⑨ Biological Mother
- ⑨ Biological Father
- ⑨ Adoptive Mother
- ⑨ Adoptive Father
- ⑨ Stepmother
- ⑨ Stepfather
- ⑨ Foster Parents
- ⑨ Other Guardian Parents

**Please list names, ages, relationship of <u>all</u> who live with child**

| Name | Age | Relationship |
|---|---|---|
| __________________ | ______ | _____________ |
| __________________ | ______ | _____________ |
| __________________ | ______ | _____________ |
| __________________ | ______ | _____________ |
| __________________ | ______ | _____________ |
| __________________ | ______ | _____________ |
| __________________ | ______ | _____________ |
| __________________ | ______ | _____________ |

**Custody:**
Who is the child's legal guardian(s)? ___________________________________________________
Who has custody? ___________________________________________________
Please describe terms of visitation.
If foster care, please describe circumstances. ___________________________________________________
Caseworkers name and phone number: ___________________________________________________

If adopted, does the child know about the adoption? ⑨ Yes ⑨ No

**Housing:**
Type of Housing:
- ⑨ Single Family House
- ⑨ Apartment/Townhome

Number of bedrooms _______
Does child share a room? ⑨ Yes ⑨ No
With whom? _____________________________

⑨ Mobile Home | Is this ⑨ parent's home?
⑨ Motel/Shelter | ⑨ staying with friend or relative?

**Other important relationships:**

Please list other people important in the child's life, people who have regular contact or influence. This list may include grandparents, siblings outside the home, sitters/daycare providers, etc.

| Name | Relationship |
|---|---|
| | |
| | |
| | |

## YOUR MAIN CONCERNS

**Description:**

Please describe as specifically as possible the child's major problems that have led you to seek consultation with us at this time.

**Problem List:**

Please list the problems identified above, and others you think of, from most severe to least severe.

| Problem | Date first noticed (approx) |
|---|---|
| 1. | |
| 2. | |

**Causes and Triggers:**

Referring to the problem number above, please describe what you believe to be the causes of these problems and identify any situations that trigger or worsen the problems. (For example: A learning disorder in spelling may cause frustration and anger triggered by spelling homework).

1.

2.

**Related Stresses and Changes:**

Have there been any changes or stressful situations lately (new baby sibling, moves, change in schools, change in visitation pattern, any traumatic events or losses, divorce of parents, etc.)?

**Impact of Problems:**

How have these problems impacted your child and family?

School behavior, grades, and peer relationships:

Home behavior and family relationships:

Neighborhood/community relationships, legal problems:

If there are any legal issues please specify charges, status, consequences, future court processes, dates if known.

## GOALS FOR EVALUATION AND TREATMENT

Please list specific goals you have for your child's evaluation and treatment. What do you hope the evaluation and treatment will accomplish? Please prioritize these goals.

1.

2.

3.

**PAST MENTAL HEALTH HISTORY**

**Current Treatment:**
Please identify current treatment providers (therapists, psychologists, primary care, school counselor, pastoral counselor etc.), type of treatment (therapy, family therapy, medication, etc.), and when treatment started.

| | Clinician Providing Treatment | Type of Treatment and effectiveness | Date Began |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**Past Treatment:**
Please identify past treatment providers similar to those above:

| | Clinician Providing Treatment | Type of Treatment and effectiveness | Approximate Dates |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**Past Psychiatric Hospitalizations:**
Please list past hospitalizations, residential placements, or other treatment programs where the child stayed outside of the home. If more than once to same facility, just list once with approximate dates.

| | Name of Facility | City/St if not local | Date |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

**MEDICATION HISTORY**
Please identify medication allergies (rashes, breathing problems, etc.) or adverse reactions (severe side effects) and describe. Include all medicines, not just psychiatric.

**Current Medications:**
Please list all current medications the child takes. Please list psychiatric medications first followed by routine medical medicines, then list frequent (monthly or more) "PRN" or "as needed" medicines (e.g. Tylenol). Please identify approximate start date for daily medicines. Please also identify herbal, "natural" medicines, or vitamins.

| Medicine | Dose | Date Started | Benefits | Suspected Side Effects |
|---|---|---|---|---|

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**Past Medications:**
Please list past psychiatric medicines used. Start with the most recent before the above current medicines. List approximate dates used. List starting and maximum doses if possible. If you need more space, please use the last page or provide a separate sheet. For example:
(Ritalin 5 mg TID to 15 mg TID 1/00 – 8/02 helped hyperactivity poor sleep and appetite)

**Medicine** **Doses** **Dates Used** **Benefits** **Suspected Side Effects**

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**PAST MEDICAL HISTORY**

**Primary Care Physician:**

Name ______________________Facility_________ Approximate date last seen _______________
Conditions being treated___________________________________________________________

**Other Physicians/Specialists:**
Name ______________________Facility _________ Approximate date last seen _______________
Conditions being treated___________________________________________________________

**Medical Conditions:**
Please identify any significant problems with conception, pregnancy, or delivery. (e.g. use of fertility agent, "high risk" status, exposure to toxic substances, premature, delayed, or emergency delivery, NICU).

Please identify any developmental disabilities, birth defects, vision, speech, or hearing problems.

Please identify any problems of early childhood (e.g. feeding problems, "failure to thrive", apnea, very high fever, delay in developmental milestones = crawling, walking, toilet training, dressing, coordination, etc.)

Please identify any chronic medical conditions requiring ongoing care. (e.g. diabetes, asthma, hemophilia, etc.)

Please identify any unusual diseases or infections (meningitis, encephalitis, tuberculosis, etc.)

Please identify any neurological problems (e.g. seizures) or significant head injury (e.g. loss of consciousness).

Please identify any intermittent but significant medical problems (e.g. severe menstrual problems, migraines).

**FAMILY HISTORY**

Please identify if any of the child's biological relatives (parents, grandparents, aunts, uncles, cousins, or siblings) have had the following conditions. Please identify the relationship using "maternal" for mother's side and "paternal" for father's side as it pertains to the child

| **Problem** | **Relative Affected** |
| --- | --- |
| (Circle specific condition or add name of related condition along with person affected) | |
| **Medical:** | |
| Cardiac (Heart disease, sudden cardiac death, high blood pressure, stroke, mitral valve prolapse/other heart condition) | |
| Diabetes | |
| Thyroid disease | |
| Epilepsy (seizures, convulsions) | |
| Tourette's Disorder, motor or vocal tics | |
| **Developmental or cognitive:** | |
| Intellectual delay | |
| Developmental delay | |
| Autism spectrum/aspergers | |
| Learning disorders (dyslexia, ADHD) | |
| ADHD, attention, hyperactive, impulse control problems | |
| **Educational:** | |
| Severe academic problems | |
| Severe school behavior problems | |
| Did not finish high school | |
| **Environmental (including non-blood relative housemates):** | |
| Suffered physical abuse, sexual abuse, or | |
| Exposure to toxins (e.g. lead, arsenic, asbestos) | |
| **Behavioral:** | |
| Aggressive criminal behavior, assaults | |
| Legal problems (repeat offenses, arrests) | |
| Violent behavior | |
| Stealing, lying, cruelty to people or animals | |
| Destruction of property, fire setting | |
| **Psychiatric:** | |
| Anxiety, OCD, phobias "nerve problems" | |
| Depression | |
| Manic depression/bipolar disorder | |
| Schizophrenia, schizoaffective, psychosis | |
| Suicide attempts or completions (specify which) | |
| Admission to psychiatric hospital | |
| Borderline personality disroder | |
| **Substance Abuse:** | |
| Alcohol use disorder | |
| DUI, especially repeat offenders | |
| Substance use disorder, "street" or prescription | |

## SOCIAL HISTORY

**Parent's Relationship:**

Describe parent's marriage relationship.

If divorced, describe relationship between divorced parents. Include issues related to custody, child support, and visitation.

Please describe types of discipline used in the home. Include privileges, responsibilities, and consequences (punishments) for the child.

**Moves:**

Please list all family moves since the child's birth. Identify the year of the move.

**Child's Issues:**

Peers:

| | |
|---|---|
| Does your child have many friends? | ⑨ Yes ⑨ No |
| Do you approve of your child's friends? | ⑨ Yes ⑨ No |

What concerns you or satisfies you about the friends?

Would you describe your child as a follower or a leader?

Substance Use:

What do you know or suspect about your child's use of nicotine, marijuana, alcohol, cocaine, or other substances?

Difficult Experiences:

History of trauma during your child/adolescent's lifetime (e.g., abuse, neglect, sexual abuse, witnessing domestic or community violence):

**Current or Most Recent School:** ⑨ Public ⑨ Private ⑨ Home School

Has your child every repeated a year? Indicate year and why.

Has your child received special education designation or services? Specify type and grade level.
This includes speech, tutoring, reading help as well as learning disorder, emotional disorder, behavior disorder, Also include advanced placement, high cap programs.

Does your child otherwise have an IEP separate from above? Is there a "504 Accommodation Plan"?

Has your child been tested for any of the above? If so, what year? Try to provide a copy of the evaluation.

**Timeline:**

For each year, include grades, behavior, and overall function

| Grade | Name of School | Average Grade | Behavior | Overall Function |
|---|---|---|---|---|

**ANYTHING ELSE?**

Use this space to answer questions you may not have had room for. Please refer to the page and section. Use this space to say anything else you would like to share.