

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: _____

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: _____
