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CHILD/ADOLESCENT PSYCHOSOCIAL

IDENTIFYING INFORMATION

Date of Assessment _____

Name of child/adolescent _____ Sex: (M)____(F)____

DOB of child/adolescent _____(dd/mm/yyyy)

PRINT Name of parent/guardian (filling form)_____

Birth date _____Place of birth _____ Age _____

Address (number & street) _____

(city) _____(state) _____(zip) _____

Home Phone () _____ Mother Cell () _____

Father Cell () _____ Guardian Cell () _____

Child's Religion (optional) _____

Education (grade) _____ Present school _____

Referral Source: (name) _____ (ph) _____

I give permission for (therapist) to contact (physician/teacher/etc) regarding treatment issues, symptoms, behaviors or other information necessary for the treatment of (minor patient).

Parent/guardian Signature _____ Date _____

Mother Email _____

Father Email _____

Guardian email _____

CHIEF COMPLAINT

Presenting Problems (check all that apply)

Very unhappy

Irritable

Temper outbursts

Withdrawn

Daydreaming

Fearful

Clumsy

Impulsive

Stubborn

Disobedient

Infantile

Mean to others

Destructive

Trouble with law

Fire setting

Stealing

Lying

Sexual trouble

School performance

Truancy

Bed wetting

Education _____ Religion _____

Birthplace _____ Birth date _____

Age _____

Father- Relationship to child ___ natural parent ___ relative
 ___ step-parent ___ adoptive parent

Occupation _____

Education _____ Religion _____

Birthplace _____ Birth date _____

Age _____

Marital History of Parents

Natural parents ___ married when _____ age _____

 ___ separated when _____

 ___ divorced when _____

 ___ deceased M or F _____

Step-parents ___ married when _____

If child is adopted:

Adoption Source:

Reason and circumstances:

Age when child first in home

Date of legal adoption

What has the child been told?

LIVING ARRANGEMENTS

PLACES

DATES

Number of moves in child's life _____

Present home ___renting ___buying
 ___house ___apt

Does child share a room w/ anyone? _____YES _____NO

If yes, with whom? _____

If no, how long has he/she had own room? _____

Was child ever placed , boarded or lived away from family? ___YES ___ NO

Explain _____

What are the major family stresses at the present time, if any? _____

What are the sources of family income? _____

BROTHERS and SISTERS: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug alcohol abuse (yes or no)
1. _____	___	___	_____	_____	___	___	___
2. _____	___	___	_____	_____	___	___	___
3. _____	___	___	_____	_____	___	___	___
4. _____	___	___	_____	_____	___	___	___
5. _____	___	___	_____	_____	___	___	___
6. _____	___	___	_____	_____	___	___	___

List all other extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Others living in the home (and their relationship):

1. _____

2. _____

HEALTH OF FAMILY MEMBERS (excluding patient)

Name	Relationship to child	Illness	When Occurred	Length of illness
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

Does or did any member of the child's family have any problems with:

reading spelling math speech

If yes, please explain:

Is there any history in the child's family of:

mental retardation epilepsy birth defects schizophrenia

If yes, please explain:

CHILD HEALTH INFORMATION

Note all health problems the child HAS HAD or HAS NOW,

	AGE		AGE
<input type="checkbox"/> High fevers	—	<input type="checkbox"/> Dental problems	—
<input type="checkbox"/> Pneumonia	—	<input type="checkbox"/> Weight problems	—
<input type="checkbox"/> Flu	—	<input type="checkbox"/> Allergies	—
<input type="checkbox"/> Encephalitis	—	<input type="checkbox"/> Skin problems	—
<input type="checkbox"/> Meningitis	—	<input type="checkbox"/> Asthma	—

- | | | | |
|---|--------------------------|---|--------------------------|
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> | <input type="checkbox"/> Headaches | <input type="checkbox"/> |
| <input type="checkbox"/> Unconsciousness | <input type="checkbox"/> | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> | <input type="checkbox"/> Accident prone | <input type="checkbox"/> |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> | <input type="checkbox"/> Anemia | <input type="checkbox"/> |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> | <input type="checkbox"/> High or Low blood press. | <input type="checkbox"/> |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> |
| <input type="checkbox"/> Tonsils out | <input type="checkbox"/> | <input type="checkbox"/> Heart problems | <input type="checkbox"/> |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> | <input type="checkbox"/> Other illness | <input type="checkbox"/> |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> | Explain _____ | |

Has the child ever been hospitalized? YES NO

If yes, please explain,

AGE	How Long	Reason
-----	----------	--------

Has the child ever been seen by a medical specialist? YES NO

AGE	How Long	Reason
-----	----------	--------

Has child ever taken or is he/she taking presently any prescribed medications?

YES NO

AGE	Medication	Reason	Currently on med
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Name of primary care physician _____

Ph () _____

DEVELOPMENTAL HISTORY

Prenatal—Child wanted Yes No Planned for? Yes No

Normal pregnancy? Yes No

If mother ill or upset during pregnancy, explain:

Length of pregnancy _____
Paternal support and acceptance (explain)

BIRTH

Length of active labor __hrs __Easy __Difficult

Full Term __Yes __No

If premature, how early: _____

If overdue, how late? _____

Birth weight __lbs __oz.

Type of delivery __spontaneous __cesarean __with instruments
 __head first __breech

Was it necessary to give the infant oxygen? __Yes __No If yes, how long: ____

Did infant require blood transfusions __Yes __No

Did infant require X-ray? __Yes __No

Physical condition of infant at birth

(if yes explain) anorexia __Yes __No

 trauma __Yes __No

 other complications __Yes __No

Mother abuse alcohol/drugs during pregnancy? __Yes __No

NEWBORN PERIOD

	Yes	No	How Long
irritability	__Yes	__No	_____
vomiting	__Yes	__No	_____
Difficulty breathing	__Yes	__No	_____
Difficulty sleeping	__Yes	__No	_____
Convulsions/twitching	__Yes	__No	_____
colic	__Yes	__No	_____
normal weight gain	__Yes	__No	_____
was breast fed	__Yes	__No	_____

DEVELOPMENTAL MILESTONES

Age at which child:

Sat up: _____

Crawled _____

Walked _____

Spoke single words _____

Sentences _____

Bladder trained _____

Bowel trained _____

Weaned _____

Describe the manner in which toilet training was accomplished

EARLY SOCIAL DEVELOPMENT

Relationship to siblings and peers:

- individual play group play
- competitive cooperative
- leadership role a follower

Describe special habits, fears, or idiosyncrasies of the child

EDUCATIONAL HISTORY

Name of school	City/State	Dates attended		Grades completed at this school
		From	to	
preschool _____	_____	_____	_____	_____
elementary _____	_____	_____	_____	_____
Jr. High _____	_____	_____	_____	_____
High school _____	_____	_____	_____	_____

Types of classes regular learning disability continuation
 emotionally handicapped acceleration

Did child skip a grade? Yes No Repeat a grade? Yes No
If yes, when and how many years? _____ Is child in appropriate grade level at present time? Yes No.

Did child have any specific learning difficulties? Yes No
Has child ever had a tutor or other special help with school work? Yes No
Does child attend school on a regular basis? Yes No
Does child appear motivated for school? Yes No
Has child ever been suspended or expelled? Yes No

Job	Employer	How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child been in therapy before? Yes No

Date	Name of Therapist	Reason
1. _____	_____	_____

Was it successful? Yes No (Please explain what was helpful and what was not)

Date	Name of Therapist	Reason
2. _____	_____	_____

Was it successful? Yes No (Please explain what was helpful and what was not)

Date	Name of Therapist	Reason
3. _____	_____	_____

Was it successful? Yes No (Please explain what was helpful and what was not)

What would you describe as your child's/adolescent's personal strengths?

What would you describe as your child's/adolescent's personal obstacles preventing him/her from healthy functioning in his/her daily life?

Any additional comments you'd like to make to the therapist about your child/adolescent?
