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CHILD/ADOLESCENT DEVELOPMENTAL HISTORY AND PAST HEALTH

Date: _____

Child/ Adolescent Name: _____ Birth Date: _____ Age: _____
Parent(s) Name: _____
Who has custody of the child? _____
Pregnancy: normal _____ complications _____
Delivery: normal _____ complications _____
Describe Complications: _____
_____
_____
_____
Colic _____ Feeding problems _____ Cried a lot _____

Describe any medical concerns, past and present: _____
_____
_____
_____
_____

Has your child/adolescent had difficulties with development in the following areas? (check all that apply):

_____ speech/language _____ toilet training _____ hearing
_____ learning _____ vision _____ sleeping
_____ eating _____ self-help skills _____ coordination

Describe these difficulties: _____
_____
_____
_____

List three strengths you see in your child/adolescent: _____
_____
_____

List three of your child/adolescent's interests: _____
_____
_____

List three things you especially like about your child/adolescent: _____
_____
_____

FAMILY HISTORY

Mother of the child/adolescent (check all that apply):

_____ recent illness or injury?
_____ significant illness or injury in the past?
_____ current health problems?
_____ history of drug abuse?
_____ history of suicide attempts?
_____ been divorced/separated?
_____ been separated from parents as child?
_____ current regular medication?
_____ history of alcohol abuse?
_____ history of family alcoholism?
_____ history of mental illness in family?
_____ long-term health problems?
_____ death of a child?

Highest education level? _____

Father of the child/adolescent (check all that apply):

_____ recent illness or injury?
_____ significant illness or injury in the past?
_____ current health problems?
_____ history of drug abuse?
_____ history of suicide attempts?
_____ been divorced/separated?
_____ been separated from parents as child?
_____ current regular medication?
_____ history of alcohol abuse?
_____ history of family alcoholism?
_____ history of mental illness in family?
_____ long-term health problems?
_____ death of a child?

Highest education level? _____

Step-Mother/Father (circle) of child/adolescent (check all that apply):

_____ recent illness or injury?
_____ significant illness or injury in the past?
_____ current health problems?
_____ history of drug abuse?
_____ history of suicide attempts?
_____ been divorced/separated?
_____ been separated from parents as child?
_____ current regular medication?
_____ history of alcohol abuse?
_____ history of family alcoholism?
_____ history of mental illness in family?
_____ long-term health problems?
_____ death of a child?

Highest education level? _____

Have any children in the family (check all that apply):

_____ received counseling or therapy before? If so, who/when? _____
_____ been in foster care or long tem care by relatives or friends?
_____ been psychologically evaluated before?
_____ repeated a grade?
_____ skipped a grade?
_____ had a long-term illness or handicap?

Is your family currently involved in the legal system? _____ YES _____ NO
If yes, please describe: _____

_____

_____

REASONS FOR CONCERN ABOUTH THIS CHILD/ADOLESCENT'S BEHAVIOR

Please put an "X" in the column closest to describing the concerns you currently have about this child/adolescent's behavior at home, school or in the community (such as with friends, sitters, neighbors and relatives).

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KIND OF BEHAVIORS YOU ARE CONCERNED ABOUT	Where it is a Concern									BRIEF COMMENTS, such as when it happens, age at which it began
	Home			School			Community			
	NoProblem	Concerned	Very Concerned	NoProblem	Concerned	Very Concerned	NoProblem	Concerned	Very Concerned	
Tells lies										
Steals										
Runs away or threatens to										
Fights/aggressive										
Demands excessive attention										
Has temper tantrums										
Uncooperative										
Disinterested, unmotivated										
Poor attention span										
Can't sit still (high energy)										
Destructive toward objects										
Wets self/bed										
Soils self/bed										
Sleep problems										
Moody										
Tries to be perfect										
Seems depressed										
Threatens suicide or attempts										
Withdrawn (too shy or quiet)										
Has few friends, isolated										
Says negative things about self										
Says negative things about others										
Hurts self										
Has fears										
Unaffectionate										
Nervous habits										
Lives in a world of his/her own										
Eating problems										
Uncoordinated										
Learning problems										
Truancy from school										
Uses drugs										
Uses alcohol										
Sets fires										
Inappropriate sexual activity										
Behaviors he/she can't stop										

MEDICAL INFORMATION

THIS CHILD/ADOLESCENT HAS HAD:	Check "No" or "Yes"			
	No	**Yes**	**Age**	**Description, Comment, Reason if Known**
On-going medical problems				
High fevers				
Convulsions				
Fainting spells				
Allergies				
Breathing difficulties				
Frequent colds				
Surgery, unconsciousness				
Eye problems				
Head injuries				
Poisoning				
Hospital care				
Hyperactivity				Medication?
Unusual injuries				
Unusual illnesses				

Has this child/adolescent ever used or is currently using:

Alcohol: _____ current _____ past _____ never

Illicit drugs: _____ current _____ past _____ never

Tobacco: _____ current _____ past _____ never

Please list current medications (prescription or over the counter) your child/adolescent is taking. Include the dosages and dates prescribed or refilled: _____

_____

_____

Physician's name: _____Phone: _____

In case of emergency, who may we call? Name:_____

Phone #: _____ Relationship: _____

Is there any additional information you think might be helpful? _____

_____

_____

_____