

Jenny Pearson, LICSW

Licensed Independent Clinical Social Worker

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CHILD/ADOLESCENT HISTORY

Date of Appt: _____

Child's name: _____ Pronouns: _____

Date of birth: _____ Age: _____ Gender: _____

Parents name/age: 1: _____ 2: _____

Parent Occupation: 1: _____ 2: _____

Stepparents: _____

Child lives with: _____

Biological siblings name/age: _____

Step siblings name/age: _____

Others in the home: _____

Nationality/heritage: _____

Primary language spoken in home: _____

REASON FOR REFERRAL

Referred by: _____

Main concerns: _____

What outcomes are you looking for? _____

MEDICAL HISTORY

Pediatrician: _____

Other physicians or therapists: _____

Previous evaluations (date, diagnosis): _____

Current medications: _____

Previous medications: _____

MEDICAL HISTORY CONTINUED

✓	Item	Age	Explanation
	Head Injury		
	Seizures		
	Surgery		
	Hospitalization		
	Serious Illness		
	Chronic/recurring Illness		
	Allergies		
	Sleep Problems		
	Eating Problems		
	Other		

FAMILY HISTORY

✓	Family History of....	Relationship to Pt	Explanation
	Depression		
	Suicide		
	Anxiety		
	Drug/alcohol problem		
	Attention/learning problem		

PREGNANCY/BIRTH HISTORY

Adopted: Y N @ _____ weeks/months from _____

Parent's Age @ Birth: _____ / _____ Length of Pregnancy: _____ Length of Labor: _____

Birth weight: _____ APGAR Scores: _____ Breast Fed: Y N Until: _____

Please describe any significant pregnancy, birthing, adoptive experiences: _____

DEVELOPMENTAL HISTORY

Milestones: Spoke first words: _____ First sentences: _____ Walked alone: _____

Toilet trained: Days: _____ Nights: _____ Medical reasons for wetting/soiling?: _____

DEVELOPMENTAL HISTORY CONTINUED

✓	Behavior	Explanation
	Crawled	
	Coordination difficulites	
	Colic	
	Sensitivities to clothes, noises, smells	
	Speech difficulties	

Please describe any treatment/therapy for delays or behavior: _____

SOCIAL DEVELOPMENT

Interests and strengths:

Does child make and keep friends?

Significant adults/extended family/supports:

Spiritual orientation:

Major losses or separations:

Y/N	Issue	Explanation
	Guns in the home	
	Inappropriate physical touch	
	Inappropriate sexual touch	
	Emotional abuse/neglect	
	CPS involvement	

EDUCATION HISTORY

Schools Attended - Preschool to Present	
Current Grade:	Teacher:

Most liked subjects: _____

Least liked subjects: _____

IEP, 504 Plan, resource help: _____

SYMPTOM CHECKLIST

✓	Symptom	Explanation and age at onset
	Poor attention/concentration	
	Forgets assignments/materials	
	Incomplete assignments/homework	
	Avoids work requiring sustained effort	
	Procrastinates	
	Difficulty with organization	
	Looses things	
	Easily distracted	
	Spacey/daydreams	
	Memory issues, forgetful	
	Fidgets, restless	
	Excess energy, "on the go"	
	Interrupts, intrudes	
	Impulsive	
	Conflict with teacher(s)	
	Suspension/expulsion	
	Change in grades	
	Excessive absence or truant	

SYMPTOM CHECKLIST

✓	Symptom	Explanation and age at onset
	Irritable, apathetic or sad mood	
	Difficulty falling or staying asleep	
	Excessive sleep	
	Fatigued, low energy	
	Change in appetite	
	Loss of interest in activities	
	Poor concentration	
	Negative self talk/poor esteem	
	Hopeless about future	
	Thoughts about death, suicide	
	Self harm, cutting, scratching	
	Thoughts about harming others	
	Severe mood swings	
	Extremely elevated mood	
	Racing thoughts, rapid speech	
	Manic behavior	
	Unrealistic worries (ie,harm to others, terrible events, competence)	
	Panic	
	Anxiety about separation	
	School refusal	
	Refuses to sleep alone	
	Avoidance of being alone	
	Overly dependent/helpless	
	Excessive need for reassurance	
	Cries easily	
	Physical complaints w/o clear cause	
	Nightmares	
	Difficulty relaxing	
	Obsessive thoughts	
	Compulsive rituals	
	Counts, checks, orders objects	

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✓	Symptom	Explanation and age at onset
	Touchy, easily annoyed	
	Looses temper, tantrums	
	Argumentative	
	Blames others for own mistakes	
	Disregards, defies requests/rules	
	Spiteful, vindictive	
	Destructive	
	Agressive or violent	
	Pattern of lying	
	Stealing	
	Lacks adequate remorse	
	Difficulty getting along with siblings	
	Difficulty getting along with peers	
	Difficulty with transitions/change	
	Misses social cues	
	Avoids or lacks peer interaction	
	Socially inappropriate	
	Limited interests	
	Fixated interests	
	Poor hygiene	
	Tics	
	Odd/bizarre ideas	
	Hallucinations (auditory, visual, sensory)	
	Delusions	

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ADDITIONAL COMMENTS

Thank you for taking the time to complete this form.

Please bring copies of any evaluations to your appointment (psychological, neuropsychological).