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Child or Adolescent History Information Form

Name of Child or Adolescent_____**M/F**_____ **Today's Date**_____

Birth Date:_____ **Age:**_____

Name of Person filling out form (Parent or Adolescent):_____

REASON FOR SEEKING TREATMENT

Please briefly explain your reason for seeking therapy for your child or adolescent at this time:

Please list any stressors in your child's or adolescent's life (or the family member's lives) at this time that may contribute to the issues. Some common contributing factors are school stresses, peer problems, chronic illness, stressful family relationships, financial stresses, parent's work or career stresses, parenting conflicts, deaths of loved ones or pets, home or school moves, alcohol or drug use, affairs, physical or emotional abuse, behavior problems, legal issues, divorce, etc.:

Please list things you have already tried to help solve your child's or adolescent's issues so far:

MEDICAL INFORMATION FOR YOUR CHILD OR ADOLESCENT

Name of the Primary Care Physician: _____

Name of Medical Practice_____

Address_____
Street

_____
City, ***State,*** ***Zip Code***

Office Phone # : (___)_____ ***Fax # : (___)***_____

May I contact the physician if needed? Please initial: Yes_____ No_____

List any major health problems for which your child or adolescent currently receives treatment:

List any history of health problems or surgeries your child or adolescent has experienced? Were there any health problems at birth, infancy, or childhood, or adolescence?

List any medications or supplements with dosages your child or adolescent is currently taking:

Name of Medication	***Dosage***	***Taken how often***	***What the Medication Treats***

SYMPTOM CHECKLIST

Following are checklists of a variety of behaviors and symptoms about your child or adolescent. I would appreciate it if you would take the time to fill these checklists out completely. This information will be extremely useful to me in my completing a more thorough and comprehensive assessment of your child or adolescent's issues. It will also enable me to shorten the initial history interview and more quickly develop an individualized treatment plan tailored especially for your child or adolescent. If there are areas you do not feel comfortable answering on paper, just let me know. Please check any of the following items that may pertain to your child or adolescent more often than not or that you have concerns about. You can also add comments in the spaces.

✔	FEELINGS OF WELL-BEING
	My child or adolescent generally feels worthwhile and likeable
	Respects self
	Feels close to people
	Cares about others
	Generally seems happy
	Enjoys life and friends
	Feels he/she is accomplishing something
	Often seems to have fun in life
	Feels hopeful
	Faith plays a part in his/her life
	Feels the future looks bright
	Believes problems can be solved
	Has a best friend
	Feels a respect and reverence for life
	Other positive feelings?

✔	SADNESS
	My child or adolescent often feels sad, down, depressed or hopeless
	Little interest or pleasure in doing things
	Poor appetite or overeating – noticeable weight change or failure to gain weight
	Trouble falling asleep, staying asleep, or sleeping too much
	Often acts slowed down or sped up
	Frequently seems tired or has little energy
	Feels excessively worthless or guilty
	Has difficulty concentrating on things or trouble making decisions
	Sometimes has thoughts of wanting to die
	Has a plan for hurting or killing self
	Other depression Symptoms?

✔	WORRIES
	Difficulty controlling worries
	Gets tired easily
	Irritable
	Muscle tension
	Difficulty falling asleep
	Wakes up in the middle of the night
	Wakes up in the early morning
	Has trouble concentrating
	Feeling keyed up or restless
	Often has significant Anxiety
	Worries about social events
	Worries about looking stupid or being embarrassed
	Has Difficulty having social conversations
	Avoids being center of attention
	Other Worries?

✔	PANIC
	Attacks of sudden intense fear
	Pounding or racing heartbeat
	Shakiness or trembling
	Shortness of breath
	Chest pain
	Nausea or abdominal distress
	Feeling dizzy or lightheaded
	Feeling things are unreal or like a dream
	Fear of losing control or going crazy
	Numbness, tingling, chills, or sweating
	Choking or smothering sensation
	Fear of dying
	Other Panic symptoms?

✔	CONCENTRATION
	Fails to give close attention to details or often makes careless mistakes
	Has difficulty staying focused on tasks …homework, conversations, chores
	Often doesn't seem to listen when spoken to …his/her mind seems elsewhere
	Doesn't follow through on instructions …fails to finish homework or chores
	Difficulty organizing tasks and activities …notebook messy, room disorganized
	Procrastinates on things…homework, chores, lengthy reports, etc.
	Often looses things necessary for tasks …. Homework, books, coats, cell phone
	Easily distracted by things or events …sometimes by own unrelated thoughts
	Often forgetful in daily activities… appointments, tests, chores, etc.

✔	ACTIVITY LEVEL
	Often fidgets with hands, taps legs, or squirms in his/her seat
	Often leaves seat where remaining seated is expected…church, classroom, etc.
	Runs or climbs about in situations in which it is inappropriate
	Difficulty playing quietly
	Often "On the Go" as if driven by a motor …Others see as hard to keep up with
	Often talks excessively…"Motor mouth"
	Often blurts out things…completes other's sentences or "jumps the gun" in talking
	Difficulty waiting for his or her turn…in conversations or while waiting in line
	Frequently interrupts or intrudes on others …Conversations, activities, games, etc.

✔	ANGER
	Trouble controlling anger
	Looses temper frequently
	Friends often get angry toward him/her
	Argues with others
	Does things deliberately to annoy people
	Feels like getting back at people
	Sometimes hurts other people or mean
	Often feels angry or resentful
	Often blames others
	Start verbal or physical fights
	Shouts or yells often
	Throws, breaks or smashes things
	Frequently Irritable
	Other anger issues?

✔	BEHAVIOR PROBLEMS
	Steals
	Lies
	Runs away from home
	Threatens or intimidates others
	Physically cruel to animals
	Destroys other's possessions
	Destroys his/her own possessions
	Sometimes gets in rages
	Stays out all night without permission
	Has used a weapon
	Has forced others to be sexual
	Has set fires
	Been involved with the law
	Alcohol or drug use concerns
	Other concerns?

✔	TRAUMATIC EVENTS
	Experienced a traumatic event
	Has suffered abuse now or in past
	Memories of the event are very upsetting
	Sometimes wets the bed
	Nightmares or bad dreams
	Avoids things or feelings about the event
	Can't remember parts of what happened
	Startles easily
	Can't stop thinking about the trauma
	Difficulty experiencing pleasure
	Feels numb inside
	Feels disconnected from others
	Often feels helpless
	Feels guilty or hopeless
	What traumatic events have happened?

✔	OBSESSIONS / COMPULSIONS
	Can't stop thinking about some things
	Can't stop doing some things
	Excessive hand washing
	Doing things too slowly or perfectly
	Excessive checking
	Difficulty making decisions
	Routines or rituals she/he can't stop
	Excessive cleaning
	Does things to prevent thoughts/problems
	Knowing actions are irrational…can't stop
	Needs things to be in order
	Feels he/she will accidentally hurt others
	Avoids things because of obsessions
	Possible Sexual Compulsions
	Other specific obsessions / compulsions?

✔	FEARS
	Afraid of_____
	Fear of animals or objects
	Uneasiness of crowded places
	Afraid to travel
	Afraid to be alone
	Unreasonable fear of something
	Fear of animals
	Fearful of people
	Uncomfortable in some social situations
	Avoiding fearful things, objects or places
	Intense anxiety at times
	Fearful of one or more person(s)
	Afraid of going to work
	Scared to be in a relationship
	Other fears?

✔	HEALTH CONCERNS
	Concerned about his/her health
	Stomachaches
	Headaches
	Pains in heart or chest
	Backaches
	Sore muscles
	Dizziness
	Fear of having a serious disease
	Frequent doctor visits
	Chronic pain or unexplained pain
	Feeling weak or often tired
	Fear of death
	Any Chronic Illnesses?
	Specific health Concerns at this time?

✔	RELATIONSHIPS WITH FAMILY
	Close to mom
	Close to dad
	Gets homesick often
	Stays overnight at friends
	Close to grandparents
	Feels compassion for others
	Does nice things for family members
	Remembers other's birthdays
	Tends to others in family who are sick
	Feels close to a pet
	Feels bad when hurts other's feelings
	Puts other's needs over his/her needs
	Close to step-parent (if applicable)
	Close to siblings

✔	RELATIONSHIP PROBLEMS
	Struggles with healthy relationships
	Often feels lonely
	Frequently disappointed by relationships
	Often doesn't feel close to others
	Lots of conflict in relationships
	Has few friends
	Often feels critical of others
	Feel others dislike him/her
	Feels inferior to others a lot
	Often self-conscious
	Extremely shy or too sensitive
	Not close to either parent
	Feels most people cannot be trusted
	Doesn't have a best friend or group
	Other Concerns?

✔	SCHOOL & CLASSROOM
	Has trouble getting homework done
	Doesn't turn in daily homework
	Misses a lot of school
	Disciplined often by teacher or principal
	History of Special Education
	Doesn't get along with other students
	Lonely in school
	Trouble using the public bathrooms
	Difficulty at lunch or recess
	Poor academic grades
	Doesn't like school or doesn't like to go
	Frequently goes to nurses office
	Learning difficulties or IEP or 504 plan
	School suspension or expulsion
	Other issues?

✔	DAILY FUNCTIONING PROBLEMS
	Has trouble sleeping
	Takes too long of naps during the day
	Overeats
	Toileting accidents or wetting the bed
	Doesn't eat enough
	Doesn't get enough exercise
	Exercises too much
	Binges on food sometimes
	Throws up after eating
	Often has constipation or diarrhea
	Risk-taking behaviors
	Hurts or cuts on self
	Thinks of dying or suicide
	Mood swings – Up and Down Moods
	Other problems?

HISTORY & DEVELOPMENT

1. ***Child Birth and Infancy***: Age of Mother at Birth of Child ____ Age of Father____
Length of Pregnancy _____ Length of Labor_____ Birth Weight _____
Breastfed_____ If so, for how long_____

Any complications with pregnancy, delivery or birth?

Any problems during the first year of life? (For example, sleep difficulties, colicky, didn't want to be held, feeding problems, allergies, ear infections, etc.)

2. ***Toddler and Preschool Years:*** Age when child: Spoke First Word____Sentences_____
Toilet Trained_____ Crawled_____ Walked_____ Ran_____

Any problems with walking or coordination, unclear speech, eating problems, underweight or overweight, sleep problems, excessive tantrums, excessive activity, crying, behavior problems, aggression, fussiness, etc.?

3. ***School Years and Educational History:*** Age when first attended Kindergarten_____

Any problems with school grades, teachers, peers, learning problems, difficult experiences?

Any problems with learning challenges or disabilities?

Does your child have a 504 or IEP Plan?

What grade is your child in now?_____ Name of school?_____

Where is your child or adolescent after school?

4. ***Social Development:***

Does your child or adolescent make or keep friends? Best friend or group?

Major support system for your child or adolescent?

Has child or adolescent experienced any physical or sexual abuse, emotional abuse or neglect, or any CPS involvement?

5. ***Overall Development:*** Any concerns regarding:

- Gross Motor Skills (running, throwing ball, bicycling…)
- Fine Motor Skills (coloring, drawing writing scissor use…)
- Speech & Language Skills (pronunciation, vocabulary…)
- Self-Control Skills (impulse control, delay of gratification…)
- Self-Concept (opinion of him or herself, abilities, worth..)
- Cognitive Skills (memory, comprehension, knowledge…)

6. Please list any ***Mental Health Treatment*** your child or adolescent has had in the past including therapists, psychologists, psychiatrists, psychiatric hospitalizations, substance abuse treatment, etc.:

7. Please list the ***strengths*** of your child or adolescent:

8. Please list your child's or adolescent's favorite ***Activities / Hobbies / Ways they Relax:***

9. What is your child or adolescent most looking forward to?

FAMILY HISTORY – Please check any of the following that your child or adolescent's biological relatives may have experienced:

	Depression		Hyperactivity (ADHD)		Alcohol Problems
	Anxiety		Bipolar Disorder		Drug Problems
	Mood Swings		Attempted Suicide		Completed Suicide
	Panic Attacks		Obsessive-Compulsive Dis		Tic Disorder
	Learning Disabilities		Problems with the Law		Jail time
	Heart Disease		Diabetes		Obesity
	High Blood Pressure		Cancer		Thyroid Problems
	Physical Abuse		Emotional Abuse		Neglect
	Sexual Abuse		Seizures		Schizophrenia
	Other:				

Thank you very much for patience in taking the time to answer all of these questions about your child or adolescent. It really helps me do a more comprehensive evaluation. If you have any questions at all about this questionnaire, please feel free to bring it up with me at our first session. Is there anything else you would like me to know that was not on this questionnaire?

Thank you!