CHILD/ADOLESCENT DEVELOPMENTAL HISTORY AND PAST HEALTH

Date: ______________________

Child/Adolescent Name:_____________________Birthdate:___________Age:__________

Parent's Name:____

Who has custody of child? ____

Pregnancy: Normal_________ Complications____________________________________

Delivery: Normal_________ Complications____________________________________

Describe Complications:

____

____

____

Colic__________Feeding problems______________Cried a lot______________________

Describe any medical concerns, past and present: ___________________________________

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____

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

_________speech, language	________toilet training	________hearing
_________coordination (sit, stand walk, etc.)	________learning	________vision
_________ self-help skills	________sleeping	________ eating

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: ___________________

____

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Continue on other side

FAMILY HISTORY

Mother of the child/adolescent:

_____recent illness or injury?
_____significant illness or injury in past?
_____current health problems?
_____history of drug abuse?
_____history of suicide attempts?
_____has been divorced or separated?
_____death of a child?
_____Mother's educational level____________
_____current regular medications?
_____history of alcohol abuse?
_____history of alcoholism in family?
_____history of mental illness in family?
_____had been separated from parents as child?
____ long-term health problems?

Father of the child/adolescent:

_____recent illness or injury?
_____significant illness or injury in past?
_____current health problems?
_____history of drug abuse?
_____history of suicide attempts?
_____has been divorced or separated?
_____death of a child?
_____Father's educational level_____________
_____current regular medications?
_____history of alcohol abuse?
_____history of alcoholism in family?
_____history of mental illness in family?
_____had been separated from parents as child?
_____long-term health problems?

Step-Mother/Father (circle) of child/adolescent:

_____recent illness or injury?
_____significant illness or injury in past?
_____current health problems?
_____history of drug abuse?
_____history of suicide attempts?
_____has been divorced or separated?
_____death of a child?
Educational level_______________________
_____current regular medications?
_____history of alcohol abuse?
_____history of alcoholism in family?
_____history of mental illness in family?
_____had been separated from parents as child?
_____long-term health problems?

Have any children in the family:

_____received counseling or therapy before?
Where?_________________________________
_____been in foster care or long term 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:
____
____

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REASONS FOR CONCERN ABOUT 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).
Put an "S" beside any area which applies to other children in the family.

KINDS 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			
	No Problem	Concerned	Very Concerned	No Problem	Concerned	Very Concerned	No Problem	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										
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										
or others										
Hurts self										
Has fears										
Unaffectionate										
Nervous habits										
Lives in 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										

____
Child/Adolescent's Name

MEDICAL INFORMATION

THIS CHILD/ADOLESCENT HAS HAD :	Check "No" or "Yes"			
	No	Yes	At 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 your child/adolescent is taking, prescriptions or over the counter. Include the dosages and dates prescribed or refilled: ___________________________________
____
____

Physician's name: ____
In case of emergency, whom may we call? Name _______________________________________
Phone # ________________ Relationship ____

THERAPIST NOTES: ____
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