Child & Adolescent History Form

Form completion date: _____

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

General Information

Name of person completing this form: _____ Relation to patient: _____

Child's Name: _____

First *Middle* *Last*

D.O.B: _____ Age: _____ Gender: _____

Home Address: _____

Phone: _____ Alternate Phone:_____

School: _____ Grade: _____

Referral Information

How were you referred to CFCG?

_____

Current Concerns

_____
_____
_____
_____
_____

How long has this problem(s) existed? _____ Years _____Months

What have you been told by others regarding your child's difficulties?_____
_____
_____
_____

What can we do to help you and your child?
_____
_____
_____
_____

Who lives in the home?

Name	Age	Relationship	Education Level	History of Emotional Difficulties

Mother's Information

Name: _____ Occupation: _____

Health Status:

_____

Mother's Marital History

Dates (FROM-TO)	Spouse's Name	How did marriage end?

Father's Information

Name: _____ Occupation: _____

Health Status:

_____

Father's Marital History

Dates (FROM-TO)	Spouse's Name	How did marriage end?

BLENDED, SEPARATED DIVORCED FAMILIES PLEASE COMPLETE THE FOLLOWING

When did the divorce/separation occur?

_____

Who is the custodial parent?

_____

Where is the non-custodial parent?

_____

Mother's Children

Name	D.O.B.	Relationship

If not remarried, does mother have significant other? ☐ Yes ☐ No

If yes, who? _____ How long married? _____

Father's Children

Name	D.O.B.	Relationship

If not remarried, does father have significant other? ☐ Yes ☐ No

If yes, who? _____ How long married? _____

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Developmental and Health History

Was the child from a planned pregnancy? ☐Yes ☐No

Was the child adopted? ☐ Yes ☐ No If yes, how old was the child at time of adoption? _____

Were there any problems during the pregnancy? (I.e. toxemia, diabetes, high blood pressure, etc.)

_____

_____

_____

Were there any problems during the labor or delivery?

_____

_____

_____

Were there any problems during the first 3 months post-delivery? (I.e. feeding, sleeping, breathing problems, other)

_____

_____

_____

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Developmental Milestones

Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.

Milestone	**Age**
Sat Alone	
Crawled	
Toilet training started	
Toilet training ended	
Stood Alone	
Walked without holding	
Rode Tricycle	

Has the child had any of the following diseases?

Name	Check yes or write N/A	If yes, what age?
Measles		
Mumps		
Chicken Pox		
Strep Throat		
Ear Infections		

Medication History

Medication Name	Dosage	Directions	Check if presently taking	Start/End Date	Reason for discontinuing

Has the child had any of the following difficulties? If yes, please explain.

	Check yes or write N/A	If yes, please explain
Accidents/Fractures		
High Fever		
Seizures		
Food Poisoning		
Lead Ingestion		
Bedwetting or Soiling		

	Check yes or write N/A	If yes, please explain
Constipation		
Vision Problems		
Hearing Problems		
Speech Problems		
Speaking Excessively Loud		
Memory Problems		
Allergies		
Aggressive Behavior		
Unusual Fears		
Sleeping Difficulties		
Head Banging		

	Check yes or write N/A	If yes, please explain
Rocking		
Temper Tantrums		
Discipline Problems		
Other		

Adolescent

(12-17 years of age)

(Please check all that apply)	Yes	No	N/A	Additional Information
Have menses begun?				Onset age?
Does he/she date?				
Is he/she sexually active?				
Has she been pregnant				If yes, results of pregnancy?
Does he/she drive?				
Does he/she work?				Where & Hours worked per week?

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Extracurricular Activities

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Does he or she have a group of close friends? ☐ Yes ☐ No

How does he/she relate to authority?

_____

_____

_____

Any of the following?

Drugs ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

Tobacco ☐ Yes ☐ No

Has he/she ever run away? ☐ Yes ☐ No

If yes, when?

_____

_____

Where did they run away to? _____ For how long? _____

Has he/she been hospitalized for emotional problems? ☐ Yes ☐ No

Please list all psychiatric hospitalizations

Type of Evaluation	Date (s)	Hospital/Facility	Treating Doctor

Has he/she ever been suspended/expelled from school? ☐ Yes ☐ No

If yes, when: _____

Why? _____

Any legal problems? ☐ Yes ☐ No

If yes, what were the circumstances?

_____

_____

Any suicidal language, gestures, or attempts? ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Academic History

Name of School	City/State	Grade(s)	Problems (if any)

Has your child been retained? ☐ Yes ☐ No

Has your child been tested? ☐ Yes ☐ No

Please list any previous evaluations (i.e. Psychological, Educations, etc.)

Place of Evaluation	Type	Address	Date

Has your child ever been is a special class placement, received remedial help, or had tutoring?
Yes ☐ No ☐

If yes, please specify

_____

_____

Relationship with Teachers (please check one)

☐ Excellent

☐ Average

☐ Poor

Relationship with Peers (please check one)

☐ Excellent

☐ Average

☐ Poor

Please bring copies of all Psychological, Educational, or other evaluations to your upcoming appointment.

Activities

What things does your child like to do?

_____

_____

_____

What things does your child do well?

_____

_____

_____

What things present difficulty for your child?

_____

_____

_____

Does your child recognize dangerous situations? ☐ Yes ☐ No

Give detailed description of an average day:

Other comments:

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Symptoms Checklist

(please check yes or no)

Symptom	Yes	No
Difficulty falling asleep		
Trouble remaining sleep		
Loss of Appetite		
Excessive Appetite		
Binge Eating		
Excessive Exercising		
Trouble Concentrating		
Trouble Sitting Still		
Feelings of Sadness		
Tearfulness		
Irritability		
Trouble Controlling Aggression		
Trouble Making Friends		
Trouble with the Law		
Ever been arrested		
Uses drugs		
Uses Alcohol		
Smokes Cigarettes		
Runs away from home		
Hears voices		
Sees visions		
Oppositional to authority		
Gets in fights		
Has been sexually abused		
Sexually molested other children		
Takes medication at this time		

Please elaborate on symptoms marked yes:

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