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CHILD/ADOLESCENT PSYCHOSOCIAL

IDENTIFYING INFORMATION **Date of Assessment ________**

Name of child/adolescent ________________________________Sex: (M)____(F)____

DOB of child/adolescent ____________________(dd/mm/yyyy)

PRINT Name of parent/guardian (filling form)_________________________________

Birth date ___________________Place of birth _______________ Age ____________

Address (number & street) ____

(city) _______________________________(state) ________ (zip) ________________

Home Phone (   ) ________________ Mother Cell (   ) _______________________

Father Cell (   ) ____________________ Guardian Cell (   ) _____________________

Child's Religion (optional) _______________

Education (grade) ________________ Present school _________________________

Referral Source: (name) _________________________ (ph) ____________________

I give permission for (therapist) to contact (physician/teacher/etc) regarding treatment issues, symptoms, behaviors or other information necessary for the treatment of (minor patient).

Parent/guardian Signature _________________________________ Date___________
Mother Email ____________________________________
Father Email _____________________________________
Guardian email __________________________________

CHIEF COMPLAINT

Presenting Problems (check all that apply)

__Very unhappy	**__Impulsive**	**__Fire setting**
__Irritable	**__Stubborn**	**__Stealing**
__Temper outbursts	**__Disobedient**	**__Lying**
__Withdrawn	**__Infantile**	**__Sexual trouble**
__Daydreaming	**__Mean to others**	**__School performance**
__Fearful	**__Destructive**	**__Truancy**
__Clumsy	**__Trouble with law**	**__Bed wetting**

__Overactive
__Slow
__Short attention span
__Distractible
__Lacks initiative
__Undependable
__Peer conflict
__Phobic
__Running away
__Self-mutilating
__Head banging
__Rocking
__Shy
__Strange behaviors
__Strange thoughts
__Suicide attempt
__Soiled pants
__Eating problems
__Sleeping problems
__Sickly
__Drug use
__Alcohol use
__Suicide talk

Explain:

How long have these problems occurred? (number of weeks, months, years)

____

What happened that makes you seek help at this time? ________________

____

Problems perceived to be: _____very serious ______ serious _____ not serious

What are your expectations of your child? ___________________________

____

What changes would you like to see in your child? ___________________

____

What changes would you like to see in yourself? _____________________

____

What changes would you like to see in your family? __________________

____

PSYCHOSOCIAL HISTORY

CURRENT FAMILY SITUATION

Mother- Relationship to child __natural parent __ relative __step-parent __adoptive parent

Occupation __________________________

Education ____________________________Religion ______________________

Birthplace ___________________________ Birth date ______________________

Age _________________________________

Father- Relationship to child __natural parent __ relative

__step-parent __adoptive parent

Occupation ___________________________

Education ____________________________Religion ______________________

Birthplace ___________________________ Birth date ______________________

Age _________________________________

Marital History of Parents

Natural parents	__ married	when_____	age____ ____
	__ separated	when_____	
	__divorced	when_____	
	__deceased	M or F ___	
Step-parents	__married	when_____	

If child is adopted:

Adoption Source:

____

Reason and circumstances:

____

Age when child first in home

____

Date of legal adoption

____

What has the child been told?

____

LIVING ARRANGEMENTS PLACES DATES

Number of moves in child's life _____ _______________ ____________

_______________ ____________

Present home ___renting __buying _______________ ____________

___house __apt _______________ ____________

Does child share a room w/ anyone? ____YES ___NO

If yes, with whom? ____

If no, how long has he/she had own room? ___________________________

Was child ever placed , boarded or lived away from family? ___YES __ NO

Explain____

What are the major family stresses at the present time, if any? ________________

____

What are the sources of family income? ___________________________________

____

BROTHERS and SISTERS: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug alcohol abuse (yes or no)
1.__________	___	__	_________	_______	____	____	____
2.__________	___	__	_________	_______	____	____	____
3.__________	___	__	_________	_______	____	____	____
4.__________	___	__	_________	_______	____	____	____
5.__________	___	__	_________	_______	____	____	____
6.__________	___	__	_________	_______	____	____	____

List all other extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

1.____

2.____

3.____

4.____

5.____

6.____

Others living in the home (and their relationship):

1.____

2.____

HEALTH OF FAMILY MEMBERS (excluding patient)

Name	Relationship to child	Illness	When Occurred	Length of illness
1.______________	___________	___________	_________	____________
2.______________	___________	___________	_________	____________
3.______________	___________	___________	_________	____________
4.______________	___________	___________	_________	____________
5.______________	___________	___________	_________	____________

Does or did any member of the child's family have any problems with:

___reading ___spelling __math __speech

If yes, please explain:

____

Is there any history in the child's family of:

__mental retardation __epilepsy __birth defects __schizophrenia

If yes, please explain:

____

CHILD HEALTH INFORMATION

Note all health problems the child HAS HAD or HAS NOW,

	AGE		AGE
__High fevers	__	**__Dental problems**	__
__Pneumonia	__	**__Weight problems**	__
__Flu	__	**__Allergies**	__
__Encephalitis	__	**__Skin problems**	__
__Meningitis	__	**__Asthma**	__

__Convulsions	__	**__Headaches**	__
__Unconsciousness	__	**__Stomach problems**	__
__Concussions	__	**__Accident prone**	__
__Head injury	__	**__Anemia**	__
__Fainting	__	**__High or Low blood press.**	__
__Dizziness	__	**__Sinus Problems**	__
__Tonsils out	__	**__Heart problems**	__
__Vision problems	__	**__Hyperactivity**	__
__Hearing problems	__	**__Other illness**	__
__Earaches	__	**Explain** ____________________	

Has the child ever been hospitalized? ___ YES ___ NO
If yes, please explain,

AGE How Long Reason

____

____

Has the child ever been seen by a medical specialist? __YES ___ NO

AGE How Long Reason

____

____

Has child ever taken or is he/she taking presently any prescribed medications?

___ YES ___NO

AGE Medication Reason Currently on med

____

____

____

____

____

Name of primary care physician ____

Ph (   ) ____

DEVELOPMENTAL HISTORY

Prenatal—Child wanted __Yes __No Planned for? __Yes __No
Normal pregnancy? __Yes __No
If mother ill or upset during pregnancy, explain:

Length of pregnancy____
Paternal support and acceptance (explain)

____

BIRTH

Length of active labor __hrs __Easy __Difficult
Full Term __Yes __No
If premature, how early: ____
If overdue, how late? ____

Birth weight __lbs __oz.
Type of delivery __spontaneous __cesarean __with instruments
__head first __breech
Was it necessary to give the infant oxygen? __Yes __No If yes, how long: ___
Did infant require blood transfusions __Yes __No
Did infant require X-ray? __Yes __No
Physical condition of infant at birth
(if yes explain) anorexia __Yes __No
trauma __Yes __No
other complications __Yes __No
Mother abuse alcohol/drugs during pregnancy? __Yes __No

NEWBORN PERIOD

			How Long
irritability	**__Yes**	**__No**	_________
vomiting	**__Yes**	**__No**	_________
Difficulty breathing	**__Yes**	**__No**	_________
Difficulty sleeping	**__Yes**	**__No**	_________
Convulsions/twitching	**__Yes**	**__No**	_________
colic	**__Yes**	**__No**	_________
normal weight gain	**__Yes**	**__No**	_________
was breast fed	**__Yes**	**__No**	_________

DEVELOPMENTAL MILESTONES

Age at which child:

Sat up: ____

Crawled____

Walked____

Spoke single words _______________________________

Sentences____

Bladder trained___________________________________

Bowel trained____________________________________

Weaned ____

Describe the manner in which toilet training was accomplished

EARLY SOCIAL DEVELOPMENT

Relationship to siblings and peers:

__individual play __group play
__competitive __cooperative
__leadership role __a follower

Describe special habits, fears, or idiosyncrasies of the child

EDUCATIONAL HISTORY

Name of school	City/State	Dates attended From	to	Grades completed at this school
*preschool*_______________	___________	_____	______	___________
*elementary*______________	___________	_____	______	___________
*Jr. High*________________	___________	______	______	___________
*High school*___________	___________	______	______	___________

Types of classes __regular __learning disability __continuation
__emotionally handicapped __acceleration

Did child skip a grade? ___Yes __No Repeat a grade? __Yes __ No
If yes, when and how many years?_________________________________ Is child in appropriate grade level at present time? ___Yes __No.

Did child have any specific learning difficulties? __Yes __No
Has child ever had a tutor or other special help with school work? __ Yes __ No
Does child attend school on a regular basis? __Yes __No
Does child appear motivated for school? __Yes __ No
Has child ever been suspended or expelled? __Yes __No

ACADEMIC PERFORMANCE

Highest grade on last report card? ____

Lowest grade on last report card?____

Favorite subject?____

Least favorite subject____

Does child participate in extracurricular activities? __Yes __No (explain)

In school, how many friends does child have: __ a lot __ a few __ none

What are the child's educational aspirations? __quit school

__graduate from high school

__go to college

Has child had special testing in school? (If yes, what were the results)

____

Psychological __Yes __No Vocational __Yes __No

List child's special interests, hobbies, skills ________________________________

____

____

____

____

____

Has the child ever had difficulty with the police? __Yes __No (If yes, explain)

Has child ever appeared in juvenile court? __Yes __No (if yes, explain)

Has child ever been on probation? __Yes __No

From	To	Reason	Probation Officer
_______________		___________________________	______________
______________		___________________________	______________

Has child ever been employed? __Yes __No

Job	Employer	How Long
______________________	______________________________	_________
______________________	______________________________	___________
______________________	______________________________	___________

Has your child been in therapy before? ___ Yes __ No

Date Name of Therapist Reason

1. _______________ _________________________ _______________________________

Was it successful? __ Yes __ No (Please explain what was helpful and what was not)

____

Date Name of Therapist Reason

2. _______________ _________________________ _______________________________

Was it successful? __ Yes __ No (Please explain what was helpful and what was not)

____

Date Name of Therapist Reason

3. _______________ _________________________ _______________________________

Was it successful? __ Yes __ No (Please explain what was helpful and what was not)

____

What would you describe as your child's/adolescent's personal strengths?

____

____

What would you describe as your child's/adolescent's personal obstacles preventing him/her from healthy functioning in his/her daily life?

____

____

Any additional comments you'd like to make to the therapist about your child/adolescent?

____

____

____

____

____