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CHILD-ADOLESCENT CONFIDENTIAL HISTORY

IDENTIFYING INFORMATION **Date of Assessment_____**

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

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

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 (if any) _____

Grade in school _____ 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 __Running away __Soiled pants __Slow __Self-mutilating

__Eating problems __Short attention span __Head banging __Sleeping problems

__Distractible __Rocking __Sickly __Lacks initiative __Shy __Drug use

__Undependable __Strange behaviors __Alcohol use __Peer conflict

__Strange thoughts __Suicide talk __Phobic __Suicide attempt __Other

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? _____

_____

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_____
	___ separated	when_____
	___ divorced	when_____
	___ never married	
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

Number of moves in child's life _____ Places & dates_____

Present home: ___renting ___buying ___house ___apartment

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/Occup ___ Grade Living in Home Alcohol/Drug Issue

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.

_____

Others living in the home (and their relationship):

_____

HEALTH OF FAMILY MEMBERS (excluding patient)

Name	Relationship	Illness	When	Length of time
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____

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: ___autism ___epilepsy ___birth defects ___schizophrenia
If yes, please explain:

_____

CHILD HEALTH INFORMATION

Note all health problems the child HAS HAD or HAS NOW and AGE
_____High fevers _____Dental problems _____Pneumonia _____Weight problems
_____Flu _____Allergies _____Encephalitis _____Skin problems _____Meningitis
_____Asthma _____Convulsions _____Headaches _____Unconsciousness _____Earaches
_____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

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
If yes, please explain: (age, how long, reason)

_____

_____

Has child ever taken or is he/she taking presently any prescribed medications?
___ YES ___NO
If yes, please explain: (age, medication, reason, currently on med?)

_____

_____

Name of primary care physician _____

Phone: ( ) _____

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:
Low Birth Weight ___Yes ___No
Trauma ___Yes ___No
Other complications ___Yes ___No If yes, please explain:_____
Mother abuse alcohol/drugs during pregnancy? ___Yes ___No

NEWBORN PERIOD
Irritability ___Yes ___No How long?_____ Vomiting ___Yes ___No How long?_____

Difficulty breathing ___Yes ___No How long?_____
Difficulty sleeping ___Yes ___No How long?_____

Convulsions/twitching ___Yes ___No How long?_____
Colic ___Yes ___No How long?_____
Normal weight gain ___Yes ___No
Was breast fed ___Yes ___No How long?_____

DEVELOPMENTAL MILESTONES

Age at which child:

Sat up: _____
Crawled_____
Walked_____
Weaned_____
Spoke single words _____
Sentences_____
Bladder trained_____
Bowel trained_____

Describe the manner in which toilet training was accomplished:

EARLY SOCIAL DEVELOPMENT

Relationship to siblings and peers:
___plays by him/herself ___enjoys group play ___competitive ___cooperative ___leadership role
___a follower ___has few friends ___has lots of friends ___has no friends
Please explain:

Describe special habits, fears, or idiosyncrasies of the child:

EDUCATIONAL HISTORY (locations, grades completed)

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 and lowest grades 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?
Psychological __Yes __No Vocational __Yes __No
If yes, what were the results:

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

Reason _____

Dates _____

Has child ever been employed? __Yes __No

Job, Employer, How Long _____

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

Date _____ Reason_____

Name of Therapist_____

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

_____

_____

Additional Therapy Treatments (date, reason, therapist, outcome)

_____

_____

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?

_____

_____

_____

_____