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CHILD/YOUTH HISTORY FORM

Child's Name: ________________________ **Age:** _______ **Birth Date:** ______________ **Sex:** *Male Female*
Person filling out this form: ______________________ **Relationship:** ______________ **Phone:** ________________
Who requested that your child be evaluated, and why? ____
Child's school:______________________________ **Grade:** __________ **Teacher:** ______________________
Special placement (if any): ________________________ **Section 504:** *Yes No* **Special Ed:** *Yes No*
Briefly state the reason for this visit:____
____
____

CURRENT LIVING SITUATION:

Child is presently living with: *Natural Mother Stepmother Adoptive Mother Foster Mother Natural Father Stepfather Adoptive Father Foster Father Grandparent(s) Aunt/Uncle Sibling Other* ______________________
How many people currently live in the household? _______ **Does the child move between multiple households?** *Yes No*
Please describe where each member of the household sleeps: ____________________________________
____
____

FAMILY HISTORY:

Is your child adopted? *Yes No* **If so, please briefly describe the age of your child when adopted, from where the child was adopted, and the circumstances of the adoption:** ____
____
Were any methods used to enhance fertility in this birth? If so, please describe:______________________________

BIOLOGIC MOTHER:

Name: ______________________________________ **Age:** ______ **Highest grade completed:**____________
Occupation: ____

Has the biologic mother or any of her relatives experienced any of the following psychological or emotional difficulties? *Please place a checkmark by the difficulty and then list the person who has or had the problem.*

- ❑ **Anxiety disorders** ______________________
- ❑ **OCD** ______________________
- ❑ **Depression** ______________________
- ❑ **Bipolar Disorder** ______________________
- ❑ **Suicide or suicide attempt(s)** ______________________
- ❑ **Cutting/Self Injury** ______________________
- ❑ **ADD/Attention difficulties** ______________________
- ❑ **Learning disabilities** ______________________
- ❑ **Aggressive or violent behaviors** ______________________
- ❑ **Psychosis or severe thought problems**______________________
- ❑ **PTSD/Post Traumatic Stress Disorder** ______________________
- ❑ **Physical or sexual abuse** ______________________
- ❑ **Alcohol abuse** ______________________
- ❑ **Other substance abuse** ______________________
- ❑ **Social difficulties** ______________________
- ❑ **Legal trouble** ______________________
- ❑ **Severe trauma** ______________________
- ❑ **Other** ______________________

Do any medical illnesses run in the biologic mother's family (i.e., thyroid, diabetes, seizures, movement disorders such as tics or other neurological problems, allergies, etc.)? ____

BIOLOGIC FATHER:

Name: ____ Age: ______ Highest grade completed:___________
Occupation: ____

Has the biologic father or any of his relatives experienced any of the following psychological or emotional difficulties? *Please place a checkmark by the difficulty and then list the person who has or had the problem.*

- ❑ Anxiety disorders ______________________________
- ❑ Depression ______________________________
- ❑ Suicide or suicide attempt(s) ______________________________
- ❑ ADD/Attention difficulties ______________________________
- ❑ Aggressive or violent behaviors ______________________________
- ❑ PTSD/Post Traumatic Stress Disorder ______________________________
- ❑ Alcohol abuse ______________________________
- ❑ Social difficulties ______________________________
- ❑ Severe trauma ______________________________
- ❑ OCD ______________________________
- ❑ Bipolar Disorder ______________________________
- ❑ Cutting/Self Injury ______________________________
- ❑ Learning disabilities ______________________________
- ❑ Psychosis or severe thought problems______________________________
- ❑ Physical or sexual abuse ______________________________
- ❑ Other substance abuse ______________________________
- ❑ Legal trouble ______________________________
- ❑ Other ______________________________

Do any medical illnesses run in the biologic father's family (i.e., thyroid, diabetes, seizures, movement disorders such as tics or other neurological problems, allergies, etc.)? ____
____

PARENTS:

How long have the child's parents been: Married: _______ Separated: _______ Divorced: _______ Living together: _______
If the parents are separated or divorced, please describe custody (physical and legal) and visitation rights. ________________________
____
If married, describe current relationship (i.e., supportive, respectful, conflicted, continuous fighting, unpredictable, etc.): ______________
____
Please list any previous marriages: ____
Are there currently any significant marital stressors? *Yes No* ***If so, please briefly explain***: ________________________
____
____

SIBLINGS:

Name	Age	Quality of Relationship	Living at home?
______________________	_______	______________________	*Yes No*
______________________	_______	______________________	*Yes No*
______________________	_______	______________________	*Yes No*
______________________	_______	______________________	*Yes No*

Have any of the siblings experienced psychological or emotional problems (suicide or suicide attempts, attention or learning difficulties, legal problems, alcohol or substance abuse, social difficulties, or medical problems)? If so, please state who and the nature of the problem.
____
____
Are there any other relatives or persons living in the home? ____
Please list *(current or past)* significant areas of conflict in the home between your child and others. ______________________________
____
____

BIRTH HISTORY:

Mother's age at time of birth: ___________ **Father's age at time of birth:** ______________________

Did the mother smoke during the pregnancy? *Yes No* **If so, how many cigarettes per day?:** ___________________

Was alcohol consumed during pregnancy? *Yes No* **If so, what was the amount per day?** _________________

Were any drugs used during the pregnancy? *Yes No* **If so, list the name of the drug and the amount:**___________

Was the delivery unusual in any way? *Yes No* **If yes, please explain:** _____________________________

____

Did you have a cesarean? *Yes No* **If yes, please describe complications:** _________________________________

Please add any comments regarding your pregnancy or delivery that might be significant: ________________________

____

INFANCY PERIOD:

Did either parent have problems with depression after the birth? *Yes No*

If yes, please briefly describe: ____

____

Did either parent have significant problems adjusting after the birth? *Yes No*

If yes, please briefly describe: ____

____

Describe any physical or emotional separations from the caregivers in the first few years of life: _________________

____

____

Was your child: ❑ Breast fed ❑ Bottle fed

DEVELOPMENTAL HISTORY:

Motor development (sitting, crawling, walking): ❑ Average ❑ Early ❑ Late

Speech and language: ❑ Average ❑ Early ❑ Late

Self-help skills (dressing, brushing, hygiene, etc.): ❑ Average ❑ Early ❑ Late

Bowel trained: ________________________ ❑ Average ❑ Early ❑ Late

Bladder trained: ________________________ ❑ Average ❑ Early ❑ Late

Started to read: ________________________ ❑ Average ❑ Early ❑ Late

COORDINATION:

Handedness ❑ Left ❑ Right ❑ Both

Please rate your child on the following skills:

Handwriting: ❑ Neat ❑ Messy ❑ Illegible

Fine motor skills: ❑ Gifted ❑ Average ❑ Poor

Hand/Eye coordination: ❑ Gifted ❑ Average ❑ Poor

Athletic abilities: ❑ Gifted ❑ Average ❑ Poor ❑ Last chosen for teams

Does your child have an excessive number of accidents compared to other children? *Yes No Uncertain*

If yes, please describe*:* ____

____

BEHAVIORS, MOODS, AND ATTITUDES:

Check all that apply:

❑ adaptable	❑ rocking	❑ able to play alone	❑ difficulty with attention
❑ impulsive	❑ easy to manage	❑ underactive/passive	❑ deals well with frustration
❑ stubborn	❑ dare-devil	❑ eating difficulties	❑ difficulty with changes
❑ cautious	❑ shy or timid	❑ sleeping difficulties	❑ responds well to challenges
❑ moody	❑ easily frustrated	❑ aggressive/violent	❑ obsessive or compulsive
❑ sensitive	❑ empathic	❑ wants to be left alone	❑ prefers things over people
❑ playful	❑ severe tantrums	❑ slow to warm up	❑ overwhelmed by challenges
❑ fearful	❑ curious	❑ temper outbursts	❑ overactive/into everything
❑ angry	❑ staring spells	❑ breath holding spells	❑ difficulty interacting with others
❑ happy	❑ affectionate	❑ head banging	❑ stuttering/speech problems
❑ sad	❑ irritable	❑ easily engages others	

Were any of the following present, to a significant degree, during the first year of life? *If so, please describe:*

❑ Did not enjoy cuddling: ____________________

❑ Was not calmed by being held: ____________________

❑ Was difficult to comfort: ____________________

❑ Was colicky: ____________________

❑ Was excessively restless: ____________________

❑ Was excessively irritable: ____________________

❑ Experienced sleep difficulties: ____________________

❑ Experienced difficulty with nursing or food: ____________________

How would you describe your child's conscience? ❑ Normal ❑ Lax ❑ Harsh ❑ Preoccupied with certain issues

Do you have any concerns about your child's self esteem? ❑ Yes ❑ No *If yes, please describe:* ______________

____

Do you have any concerns with regard to your child's sexual knowledge or awareness? ❑ Yes ❑ No

Gender identity? ❑ Yes ❑ No **Sexual orientation?** ❑ Yes ❑ No *If yes, please describe:* ________________

____

____

Please check any of the following that this child has problems with (currently or in the past):

❑ bed wetting	❑ depression/ withdrawn	❑ obsessive-compulsive behaviors	❑ anxiety/panic
❑ soiling	❑ significant weight change	❑ self-conscious, embarrassed	❑ shy
❑ sleep problems	❑ oppositional/ defiant	❑ irritability, anger	❑ fighting
❑ lying	❑ setting fires	❑ cruelty to animals	❑ stealing
❑ eating problems	❑ secretiveness	❑ crying episodes	❑ immaturity
❑ sexual problems	❑ extreme moodiness	❑ bullied by others	❑ bully
❑ poor motivation	❑ change in personality	❑ suspicious, distrustful	❑ hallucinations
❑ alcohol abuse	❑ other substance abuse	❑ strange ideas or behaviors	❑ impulsiveness
❑ explosive episodes	❑ property destruction	❑ self-destructive behaviors	❑ running away
❑ aggression/violence	❑ frequent accidents	❑ suicidal talk or behaviors	❑ guilt
❑ hopelessness	❑ bad group of friends	❑ Other ______________________	

Please list the types of discipline you have tried with your child and its effectiveness: ____________________

____

____

Please check any of the following significant events that have occurred within your family and briefly describe:

❑ death of a family member or significant person: ____________________
❑ significant moves: ____________________
❑ trauma: ____________________
❑ divorce/separations: ____________________
❑ serious illness of a family member: ____________________
❑ parental unemployment: ____________________
❑ financial stress: ____________________
❑ trouble with the law: ____________________
❑ other: ____________________

Please express any additional concerns regarding your child: ____________________

____

____

Please list your child's strengths (i.e., academic, athletic, personality, creativity, funny, etc.): ____________________

____

____

____

Does your child have an important pet in their life? If so, please explain. ____________________

____

COMPREHENSION AND UNDERSTANDING:

Does you believe your child is able to understand directions and situations as well as other children his/her age? ❑ Yes ❑ No

If not, please explain: ____________________

____

If your child tells a story about a show, event, etc., do you or others have difficulty understanding him/her? ❑ Yes ❑ No

If yes, is it because he/she (check all that apply):

❑ appears confused ❑ is disorganized ❑ leaves out important information
❑ loses train of thought ❑ has trouble finding the right words ❑ has trouble engaging others

Does your child have trouble remembering things that he/she really cares about? ❑ Yes ❑ No

Please describe: ____________________

____

Does your child have difficulty following routines (bedtime, dressing, etc.)? ❑ Yes ❑ No

Please describe: ____________________

____

Does your child frequently lose things or have trouble being organized? ❑ Yes ❑ No

Please describe: ____________________

____

How would you rate your child's overall level of intelligence compared to other children?

❑ Gifted ❑ Above Average ❑ Average ❑ Below average ❑ Extremely low

How would your child rate his/her intelligence compared to other children?

❑ Gifted ❑ Above Average ❑ Average ❑ Below average ❑ Extremely low

INDEPENDENT ACTIVITIES:

Please describe your child's ability to function in an independent manner: ____
____
____
____

SCHOOL HISTORY:

Did your child attend daycare or preschool? ❑ **Yes** ❑ **No** *If yes, please estimate approximately how many hours per week:* ______
What are your current care arrangements for this child before and after school? ________________________________
____

Beginning with kindergarten, please list schools and indicate performance:

Grade	*School*	*Academic Performance*	*Behavioral Performance*
KG	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
1st	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
2nd	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
3rd	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
4th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
5th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
6th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
7th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
8th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
9th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
10th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
11th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor
12th	____________________	❑ Good ❑ Fair ❑ Poor	❑ Good ❑ Fair ❑ Poor

Are there any known learning disabilities? ❑ **Yes** ❑ **No**
If yes, please list: ____
____

Are any of the following unusually difficult for your child, compared to other kids?

❑ **reading quietly**	❑ **reading out loud**	❑ **sounding out unknown words**	❑ **taking tests**
❑ **learning basic math skills**	❑ **showing work**	❑ **algebra**	❑ **geometry**
❑ **writing in cursive**	❑ **spelling**	❑ **grammar**	❑ **getting started writing**
❑ **taking notes**	❑ **copying from the board**	❑ **remembering to do homework**	❑ **turning in homework**

Has your child been in any special programs such as speech, reading, occupational therapy, etc? ❑ Yes ❑ No
If yes, please explain and list grades: ____
____

Has your child ever had to repeat a grade? ❑ Yes ❑ No
If yes, please explain: ____

CURRENT ACADEMIC PERFORMANCE:

Your child's current performance at school is:

❑ Excellent ❑ Good ❑ Satisfactory ❑ Unsatisfactory ❑ Failing

Does your child enjoy school? ❑ Yes ❑ No **Did your child enjoy a previous school more:** ❑ Yes ❑ No

School subject strengths: ____

School subject weaknesses: ____

Check any of the following problems your child has with school:

❑ **problems with written language** ❑ **poor handwriting** ❑ **poor at spelling** ❑ **poor reader**
❑ **does not remain seated** ❑ **frequently sent out of class** ❑ **too withdrawn or passive** ❑ **impulsive**
❑ **forgets instructions** ❑ **interferes with other's tasks** ❑ **difficulty being quiet** ❑ **poor at math**
❑ **requires additional supervision** ❑ **talks inappropriately** ❑ **makes careless mistakes** ❑ **daydreams**
❑ **messy and disorganized** ❑ **non-compliant in class** ❑ **oppositional with teachers** ❑ **skips school**
❑ **does not complete classroom work** ❑ **fails to check homework** ❑ **difficulties in groups** ❑ **bullied**
❑ **excessive time to complete assignments** ❑ **difficulties with peers** ❑ **not interested in friends** ❑ **socially immature**
❑ **poor attention span** ❑ **doesn't think he/she is smart** ❑ **low frustration tolerance** ❑ **hates PE/gym**
❑ **does not do homework** ❑ **testing anxiety** ❑ **mind goes blank during tests**

Please check all pro-social extracurricular activities that your child is involved in:

❑ **athletics** ❑ **music** ❑ **theater** ❑ **dance** ❑ **volunteering/community service**
❑ **school clubs** ❑ **computer groups** ❑ **debate** ❑ **citizenship/government** ❑ **business/ Junior Achievement**
❑ **martial arts** ❑ **part-time job** ❑ **caring for siblings** ❑ **other**

PEER RELATIONSHIPS:

Does your child seek friendships with peers? ❑ Yes ❑ No
Is your child sought by peers for friendship? ❑ Yes ❑ No

Check any of the following which describes your child's interactions with peers?:

❑ **plays well in groups** ❑ **teased by other kids** ❑ **no problems**
❑ **cooperative** ❑ **supportive** ❑ **shares well**
❑ **plays primarily with younger kids** ❑ **plays primarily with older kids** ❑ **afraid other kids do not like them**
❑ **trouble making friends** ❑ **loses friends** ❑ **no friends**
❑ **few friends** ❑ **rejected by other kids** ❑ **leader**
❑ **easily led by others** ❑ **aggressive or mean** ❑ **frequent arguments**
❑ **frequent fights** ❑ **bossy and controlling** ❑ **teasing**
❑ **jealous** ❑ **bragging/boastful** ❑ **uncooperative**
❑ **feelings get hurt easily** ❑ **risky or dangerous behavior** ❑ **involved in delinquent behavior**
❑ **involved in alcohol or substance abuse**

Please add any additional comments regarding school functioning: ____

____

____

____

____

CHILD'S MEDICAL HISTORY:

If your child's medical history includes any of the following, please note the age when the incident or illness occurred and any other pertinent information.

- ❑ hospitalizations ________________________________
- ❑ handicaps or deformities ____________________________
- ❑ pneumonia____
- ❑ allergies _______________________________________
- ❑ skin problems ___________________________________
- ❑ tubes placed ____________________________________
- ❑ persistent high fevers ____________________________
- ❑ tics or repetitive movements________________________
- ❑ other physical trauma _____________________________
- ❑ encephalitis _____________________________________
- ❑ hearing problems _________________________________
- ❑ stomach problems ________________________________
- ❑ poisoning ____
- ❑ operations _____________________________________
- ❑ failure to grow____
- ❑ asthma ____
- ❑ diabetes _______________________________________
- ❑ multiple ear infections______________________________
- ❑ seizures _______________________________________
- ❑ obesity ____
- ❑ head injury; loss of consciousness __________________
- ❑ coma ____
- ❑ eye problems ___________________________________
- ❑ anemia ____
- ❑ constipation ____________________________________
- ❑ other ____

Has your child ever had a neurologic evaluation (neuro exam, MRI, CAT Scan, EEG, etc.)? ❑ Yes ❑ No

If so, please describe:____

____

Has your child's vision been tested? ❑ Yes ❑ No ❑ Normal **Date:** ________________

His your child's hearing been tested? ❑ Yes ❑ No ❑ Normal **Date:** ________________

Please list all medications that your child has taken for longer than one month. If possible, please describe your child's response to the medications as well as notable side effects. If additional space is needed for comments, please continue on reverse side.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

CHILD'S PRESENT MEDICAL STATUS:

Height: __________ **Weight:** __________ **Medical Doctor/pediatrician:** ____
List any present illness(es) for which your child is being treated: ____
____
____
When was your child's last physical exam? ________________________ **Was blood work done?** _________________________
Describe your child's appetite and diet: ____
____

List all medications your child is currently taking for medical problems:

Problem	Medication	Dose	Date started	Response	Side effects
____________________	____________________	________	________	_____________	______________________
____________________	____________________	________	________	_____________	______________________
____________________	____________________	________	________	_____________	______________________
____________________	____________________	________	________	_____________	______________________

Have there been any allergic reactions to medications? ❑ Yes ❑ No *If so, please describe:* ___________________
_
How does your child sleep at night? ____
____

Does your child frequently complain of: *Please check all that apply*

❑ **headaches** ❑ **dizziness** ❑ **sleep problems** ❑ **nightmares**
❑ **stomachaches** ❑ **staring into space** ❑ **tiredness** ❑ **difficulty breathing**
❑ **painful urination** ❑ **chest pain** ❑ **trouble with vision** ❑ **trouble hearing**
❑ **menstrual problems** ❑ **skin problems** ❑ **heart palpitations**

Who is/are your child's current medical doctor(s)? ____
What is the nature of your child's relationship with their doctor? ____
May I contact him/her if needed? ❑ **Yes** ❑ **No**

FREE TIME:

Please describe how your child generally spends her/his free time:

❑ plays alone ❑ plays with friends ❑ plays sports ❑ watches TV ❑ internet
❑ plays video games alone ❑ plays video games with friends ❑ reads ❑ draws/art projects ❑ builds things
❑ listening to/playing music ❑ texting/talking with friends ❑ skateboard ❑ bicycle ❑ other: __________
____

Please list the approximate number of hours per day that your child watches TV and list the type(s) of shows watched: ___________
____

Please list the approximate number of hours per day that your child plays video games and list the type(s) of games played: ________

PREVIOUS MENTAL HEALTH TREATMENT

Has your child ever received any type of psychiatric, psychological, or academic evaluation or treatment? ❑ **Yes** ❑ **No**
If so, please fill in the following:

Person or institution	Date	Address	Telephone
______________________________	__________	___________________________________	________________
______________________________	__________	___________________________________	________________
______________________________	__________	___________________________________	________________

Has your child ever taken psychiatric medications? ❑ **Yes** ❑ **No**
If yes, please list:

Problem	Medication	Dose	Date Started	Response	Side Effects
____________________	_____________	_______	_______________	_____________	______________________
____________________	_____________	_______	_______________	_____________	______________________
____________________	_____________	_______	_______________	_____________	______________________
____________________	_____________	_______	_______________	_____________	______________________

Have you been satisfied with previous mental health care (if applicable)? ____
____
____

CURRENT/PREVIOUS NATURAL TREATMENTS:

Please list any vitamins, remedies, or holistic treatments you use with your child. ______________________________________
____
____

SPIRITUAL ORIENTATION:

Please list your family's spiritual orientation or religion: ____
How active are these beliefs in your life? ❑ Very active ❑ Somewhat active ❑ Not very active
If you like, share some of your thoughts on your spiritual practice/religion: ____
____
____
____

IN CONCLUSION:

Please make any additional comments you wish with regard to your child: ____
____
____
____
____
____

Thank you for your patience and hard work in completing this form. It will help in my work with you.