Child/Adolescent Psychosocial

Date _____

Name of Child: _____ **Grade:** _____
Birth Date: _____ **School:** _____
Address: _____
_____
_____

Phone Information (please indicate whose phone number each belongs to)
Preferred Phone: _____
Alternate Phone: _____
Alternate Phone: _____
E-mail: _____

Please complete this sentence:
I am seeking treatment at this time because _____
_____
_____
_____

List three (3) specific concerns: _____
_____
_____

CHIEF COMPLAINTS:
(Check all that apply)

___ Very unhappy	___ Impulsive	___ Fire Setting
___ Irritable	___ Stubborn	___ Stealing
___ Withdrawn	___ Disobedient	___ Lying
___ Temper Outbursts	___ Infantile	___ Sexual Acting Out
___ Day Dreaming	___ Mean to Others	___ School Performance
___ Fearful	___ Destructive	___ Truancy
___ Clumsy	___ Trouble with the law	___ Bed Wetting
___ Overactive	___ Self-Mutilating	___ Running Away
___ Short Attention Span	___ Sleeping Problems	___ Distractible
___ Lacks Initiative	___ Rocking	___ Shy
___ Peer Conflict	___ Drug Use	___ Alcohol Use
___ Phobic	___ Suicide Talk	

How long have these problems been a concern? _____

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

_____

What changes would you like to see in yourself? _____

_____

_____

PSYCHOSOCIAL HISTORY:

Mother's Name: _____ **Birth Date:** _____ **Age:** _____
Biological Parent ___ **Adoptive Parent** ___ **Step-Parent** ___ **Relative** ___
Occupation: _____ **Employer:** _____
Education: _____

Father's Name: _____ **Birth Date:** _____ **Age:** _____
Biological Parent ___ **Adoptive Parent** ___ **Step-Parent** ___ **Relative** ___
Occupation: _____ **Employer:** _____
Education: _____

Parents: __Married When _____ Ages: _____ _____
__Separated When _____
__Divorced When _____
__Deceased When _____ M or F

Step-Parents __Married When _____ M or F
Step-Parents __married When _____ M or F

If this child is adopted: At what age was s/he adopted? ____ **Adoption source?** _____
Is the child aware that s/he is adopted? Y or N

What are the major 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	Grade	Living at Home	Use Drugs or alcohol	Learning Issues
1.	_____		___	___	Y/N	Y/N	Y/N Explain*
2.	_____		___	___	Y/N	Y/N	Y/N Explain*
3.	_____		___	___	Y/N	Y/N	Y/N Explain*

***Learning Issues:** _____

Others living in the home? _____

List all extended family members who have/had drug or alcohol related problems:

1. _____
2. _____
3. _____

HEALTH OF FAMILY MEMBERS:

	Name	Relationship to Child	Type of Illness	Length of Illness
1.				
2.				
3.				

CHILD'S HEALTH INFORMATION: (check and indicate age)

1.	___High Fevers	___	___Concussions	___
2.	___Allergies	___	___Asthma	___
3.	___Convulsions	___	___Stomach Problems	___
4.	___Headaches	___	___Anemia	___
5.	___Vision Problems	___	___ Hearing Problems	___

Other: _____

Has your child ever been hospitalized? If yes, please explain: _____

_____

Has your child received all of his/her vaccines? Y/N

Has your child ever had Strep Throat? Age(s) ____ ____

Is your child currently taking any medication? If yes, indicate reason, medication, length of time and current dosage

1. _____ _____ ____ _____
2. _____ _____ ____ _____

Name of Prescribing Doctor _____ **Phone:** _____
Name of Primary Care Doctor _____ **Phone:** _____

BIRTH HISTORY:

Length of pregnancy _____ **Problems with pregnancy?** _____

Did mother use drugs (prescribed or otherwise) or alcohol during pregnancy? Y/N

Explain _____

Child's Birth Weight _____ **Any other problems following delivery?**_____

NEWBORN PERIOD:

1. Irritability Y/N
2. Vomiting Y/N
3. Difficulty breathing Y/N
4. Difficulty sleeping Y/N
5. Convulsions Y/N
6. Colic Y/N
7. Normal weight gain Y/N

Did your child reach developmental milestones on time? Y/N If No, please explain

_____

Were there ever any concerns about your child's early development (e.g., speech, gross motor, fine motor)? If Yes, please explain _____

EARLY SOCIAL DEVELOPMENT:

Describe any special habits, fears, or idiosyncrasies of the child?

EDUCATIONAL HISTORY:

	Name of School	Grades Attended
1. Pre-School	_____	From ____ to ____
2. Elementary	_____	From ____ to ____
3. Middle School	_____	From ____ to ____
4. High School	_____	From ____ to ____
5. College	_____	From ____ to ____

Did your child skip a grade? _____ Has your child ever been retained? _____
Has your child ever been evaluated for learning issues? Y/N If Yes, please describe testing and findings:

Has your child ever been tutored? If yes, in what subject(s)? _____ Length of time tutored ___

Academic Performance: Best subject? _____ Most difficult subject? _____

Does your child participate in extra-curricular activities?

List your child's special interests, hobbies, skills:

1. _____
2. _____
3. _____

Has your child ever been in trouble with the police? Y/N If Yes, please explain:

Do you have any concerns about your child's social relationships?

Do you have any other concerns that have not been discussed here?