

CHILD AND ADOLESCENT MEDICAL/DEVELOPMENTAL HISTORY

Please complete the following questionnaire as thoroughly as possible.

Child's Name: _____
Birth Date: _____
Race/Ethnicity: _____

Age: _____
Gender: _____
Today's Date: _____

This form was completed by: _____
Relationship to child: _____

Child's Home Address: _____

Child's Legal Guardian(s): _____
Relationship to Child: _____
Guardian's Social Security Number _____
Guardian's Address: _____

Are there currently any custody disputes about the child? ☐ Yes ☐ No

If yes, please explain: _____

Child's School: _____
Child's Teacher: _____

Grade: _____
School Phone: _____

Presenting Concerns

1. Please list three main concerns you have about your child:

- a) _____

b) _____

c) _____

2. How long ago did your child's problems begin? _____

3. Were there any important events that happened at about the same time that your child's behavior changed? _____

4. What do you think caused the problems? _____

5. What have you tried to do to help your child with his/her problems and how has this worked?

Family Background

6. Below list all of the people with whom your child is currently living, their relationship to your child (e.g., mom, stepfather, sister, adopted brother, etc.), and describe what that relationship is like.

<i>Name</i>	<i>Age</i>	<i>Relationship to your child</i>	<i>How well does your child get along with him/her?</i>

7. Please list others whom you feel have an important impact on your child's life:

8. Please provide details about your child's parents/stepparents:

<i>Name</i>	<i>Age</i>	<i>Living</i>	<i>Occupation</i>	<i>Health</i>
		Yes/No		
		Yes/No		
		Yes/No		
		Yes/No		

9. If your child lives in more than one residence please describe the visitation arrangements:

10. List the dates of marriages and divorces of the child's parents, including current:

<i>Parent's Name</i>	<i>Date of Marriage</i>	<i>Date of Divorce</i>

11. Are the child's primary caregivers someone other than their parents? ☐ Yes ☐ No

If yes, Name: _____

Relationship to child: _____

Name: _____

Relationship to child: _____

12. Who supervises your child when the primary caregivers are at work? (Check all that apply)

☐ Day care center ☐ Private Sitter ☐ Child stays by him/herself ☐ Relative

☐ School ☐ Other (please specify) _____

13. Has your child ever lived outside of the home (for example: foster care, relatives)?

When? _____

With whom? _____

14. Has your child experienced any of the following? If yes, please explain.

☐ Physical abuse (i.e., either by an adult or peer) _____

☐ Sexual molestation, sexual abuse _____

☐ Emotional abuse or neglect _____

☐ Death of parent, sibling, or other close relative _____

☐ Removal from the home due to abandonment or neglect _____

☐ Alcohol or drug abuse by a parent or sibling _____

☐ Witnessed violence or abuse of others in the home _____

☐ Criminal arrest and/or court proceedings (e.g., juvenile arrest, custody dispute) _____

☐ Serious illness or disability; either the child him/herself or in a close relative _____

☐ Separation from one or both parents for an extended period of time _____

☐ Other situations that may have been traumatic _____

Developmental History

15. Were the child's biological parents married before the pregnancy? ☐ Yes ☐ No

If yes, for how long? _____

16. How many pregnancies did the mother have before this pregnancy? _____

17. Did any of the mother's pregnancies before this one end in an abortion, miscarriage or stillbirth? ☐ Yes ☐ No

If yes, please explain: _____

18. Was this pregnancy planned? ☐ Yes ☐ No

19. Age of **mother** when pregnant with this child? _____ Age of **father**? _____

20. Did the mother take medications while pregnant? ☐ Yes ☐ No

If yes, explain: _____

21. Did the mother use alcohol or drugs during the pregnancy? ☐ Yes ☐ No

If yes, explain: _____

22. Did the mother smoke while pregnant? ☐ Yes ☐ No

If yes, amount/day? _____

23. Complications of this pregnancy included: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Poor Nutrition |
| <input type="checkbox"/> Breech Birth | <input type="checkbox"/> Poor Emotional Health | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Mother's Loss of Consciousness | |

☐ Other: _____

24. Length of labor and type of anesthesia used: _____

25. Was the baby born prematurely? ☐ Yes ☐ No

If yes, how many weeks early? _____

26. Did the baby need special medical help at birth? For example, did the baby have trouble breathing during or shortly afterwards? ☐ Yes ☐ No

If yes, please explain: _____

27. Did the mother have any complications at birth? ☐ Yes ☐ No

If yes, please explain: _____

28. How much did the baby weigh at birth? _____

29. Did the baby have birth defects? ☐ Yes ☐ No

If yes, please explain: _____

30. Did the baby have medical problems during the first year? ☐ Yes ☐ No

If yes, please explain: _____

31. Breast-fed to age: _____ Bottle-fed to age: _____

32. Feeding problems (Check all that apply)

☐ Colic ☐ Diarrhea ☐ Spasms ☐ Vomiting
☐ Constipation ☐ None ☐ Other (Please Explain) _____

33. How did the baby sleep during the first few months? _____

34. Who was the baby's main caretaker? _____

35. The baby was (check all that apply):

☐ Cranky ☐ Difficult ☐ Calm ☐ Persistent
☐ Overly Active ☐ Social ☐ Shy ☐ Curious
☐ Hard to Please ☐ Easy ☐ Demanding ☐ Sleepy/Slow Moving
☐ Hard to Cuddle ☐ Alert ☐ Head-banging

36. At what age did the child first do the following?

Age	Age	Age
_____ Crawl	_____ Understand first words	_____ Toilet-training
_____ Stand Alone	_____ Speak first words	
_____ Walk Alone	_____ Speak in sentences	

37. Did bed-wetting or bed soiling occur after toilet-training? ☐ Yes ☐ No

If yes, please describe: _____

38. Has your child had difficulty with any of the following speech problems? (Check all that apply)

☐ Pronouncing words correctly
☐ Understanding what is being said to him/her
☐ Using words correctly in a phrase or sentence
☐ Stuttering

If yes, please describe: _____

39. Has your child had difficult with any of the following problems? (Check all that apply)

- ☐ Abnormal height or weight ☐ Night terrors ☐ Bed-wetting
☐ Sleepwalking ☐ Thumb-sucking ☐ Nail-biting
☐ Unusual Fears ☐ Sleep problems ☐ Eating problems
☐ Other (Please Explain) _____

40. At what age did your child show curiosity about sex? _____

Describe the nature of questions and how this was handled: _____

41. At what age did your child begin puberty? _____

Describe any problems: _____

42. Who usually disciplines child? _____

What methods are used? _____

Which seems most effective? _____

43. How do you reward your child? _____

44. Did your child ever share a room with anyone? ☐ Yes ☐ No

If yes please specify:

<i>Name of Person</i>	<i>Age</i>	<i>Relationship to Child</i>	<i>From</i>	<i>Until</i>

Medical History

45. Please list below dates and reasons for any operations and hospitalizations:

<i>Operation/Hospitalization</i>	<i>Age at Time</i>	<i>Problems/Aftereffects</i>

46. Please indicate if your child has experienced any of the following and the age at which they were experienced:

<input type="checkbox"/> Vision (wears glasses, etc.)	Age	<input type="checkbox"/> Hearing (hearing aids, etc.)	Age
<input type="checkbox"/> Chronic ear infections	_____	<input type="checkbox"/> Coordination (running, throwing, writing)	_____

If yes, please describe: _____

	Age		Age		Age
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> German Measles	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> GYN Disease	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Appendicitis _____		<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Scoliosis	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart Murmur	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Blood Clots	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Sickle Cell	_____
<input type="checkbox"/> Blood Pressure	_____	<input type="checkbox"/> High Fevers _____		<input type="checkbox"/> Sinusitis	_____
<input type="checkbox"/> Broken Bones	_____	<input type="checkbox"/> HIV	_____	<input type="checkbox"/> Skin Rashes	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Hives	_____	<input type="checkbox"/> T.B.	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Kidney Disease	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> Dental	_____	<input type="checkbox"/> Liver Trouble	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Lockjaw	_____	<input type="checkbox"/> Typhoid Fever	_____
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> VD	_____
<input type="checkbox"/> Encephalitis _____		<input type="checkbox"/> Meningitis	_____	<input type="checkbox"/> Whooping Cough	_____
<input type="checkbox"/> Fainting/Dizzy	_____	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Gall Bladder _____		<input type="checkbox"/> Pneumonia	_____		

Please list below any illnesses/long-term medical conditions.

<i>Illnesses/Persistent Conditions</i>	<i>Age of Onset</i>	<i>Treatment</i>
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47. Has your child ever had a head injury, fainted, or lost consciousness? ☐ Yes ☐ No
If yes, please explain. Please include the age of your child when this occurred.

48. Please list below any serious accidents/falls that your child has experienced.

<i>Accidents/Falls – what happened</i>	<i>Age at Time</i>	<i>Treatment and aftereffects</i>

49. Please list below any medications that your child is currently taking.

<i>Current Medications</i>	<i>Dosage</i>	<i>Reason Prescribed</i>	<i>Side effects</i>

50. Date of last physical? _____
Name of your child's physician _____

Mental Health History

51. Have you sought mental health treatment for your child before? ☐ Yes ☐ No
If yes, please list the professional, reasons for treatment, and dates seen

<i>Name of Mental Health Professional</i>	<i>Dates Seen</i>	<i>Reason for Treatment</i>

52. Has your child ever been hospitalized for a psychiatric condition? ☐ Yes ☐ No
If yes, please list hospitalizations and reasons/dates of hospitalization below.

<i>Name of Hospital</i>	<i>Dates Seen</i>	<i>Reason for Treatment</i>

53. Please indicate if anyone in your family, including your child, has experienced any of the following conditions. Check the item and state their relationship to your child.

Condition -- Indicate who (e.g. child, mother, brother, etc.)

- ☐ ADHD/ADD _____
- ☐ Alcohol Abuse _____
- ☐ Anorexia/Bulimia _____
- ☐ Anxiety/Nervousness _____
- ☐ Bipolar Disorder/Manic Depression _____
- ☐ Dementia _____
- ☐ Depression _____
- ☐ Drug Abuse _____
- ☐ Growth Problems _____
- ☐ Mental Retardation _____
- ☐ Physical disability (blindness, hearing, loss of limb) _____
- ☐ Schizophrenia _____
- ☐ Seizures/convulsions/Epilepsy _____
- ☐ Sudden Death _____
- ☐ Suicide Attempt _____
- ☐ Other illness, please explain _____

Academic History

54. Did your child attend nursery school? ☐ Yes ☐ No If yes, at what age? _____
Describe any problems your child had: _____

55. How old was your child when he/she first went to an out-of-the-home "school" program? _____

56. List below, beginning with Kindergarten and account for each school year

<i>School Year</i>	<i>Grade</i>	<i>Age</i>	<i>Name of School</i>	<i>Passed/Retained</i>	<i>Note any problems</i>

57. What is your child's best school subject? _____
 What is your child's worst school subject? _____

58. Which of the following best describe your child's school behavior and attitude: (Check all that apply)

- ☐ happy ☐ sad ☐ well-adjusted ☐ doesn't want to attend
☐ fearful ☐ hurts other kids ☐ has difficulty learning ☐ argues with the teacher
☐ withdrawn ☐ disruptive ☐ refuses to work ☐ doesn't make friends
☐ poor attention ☐ distracted easily ☐ does not remain seated
☐ other (please explain) _____

59. Has your child ever had academic, cognitive, or psychological testing? ☐ Yes ☐ No

If yes:

<i>Age</i>	<i>By whom</i>	<i>What were the results?</i>

60. Has your child ever been diagnosed with a learning disability? ☐ Yes ☐ No

If yes, please explain in which areas: _____

61. Does your child receive special education services? ☐ Yes ☐ No

If yes, please explain:

<i>Why</i>	<i>For what type of class</i>	<i>Grade(s)</i>

62. Has your child ever been suspended or expelled? ☐ Yes ☐ No

If yes, please explain:

<i>Grade</i>	<i>Why</i>

63. Does your child do his/her homework regularly? ☐ Yes ☐ No

On average how long does your child spend on homework each night? _____

Who helps your child with homework if help is needed? _____

Legal History

64. Is your child now / ever been involved with the juvenile justice system? ☐ Yes ☐ No

If yes, at what age and why? _____

65. Is your child or an immediate family member involved in any lawsuits or other legal problems at the present time? ☐ Yes ☐ No

If yes, please explain _____

Social History

66. Is your child able to care for him/herself (dress, eat, hygiene, making change, telling time, using phone) in a manner appropriate for his/her age? ☐ Yes ☐ No

If no, please explain: _____

67. Please list the activities or special interests that your child most enjoys. For example: Swimming, baseball, reading, dolls, fishing, etc. _____

Has your child's interests in these activities declined recently? _____

68. Compared to other same age children, how well does he/she do these activities?

☐ Poor ☐ Fair ☐ Average ☐ Very Well

69. Compared to other children of the same age, how much time does he/she spend in these activities? _____

70. Please list any organizations, clubs, teams or groups your child belongs to and describe how active he/she is in these: _____

71. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, etc. Also, please describe how well he/she carries out these jobs/chores: _____

72. Does your child prefer to play with others or alone? ☐ Others ☐ Alone

What activities, if any, does your child enjoy with other children? _____

73. Does your child play better with younger peers, same aged peers, or older peers?

☐ Younger ☐ Same age ☐ Older

How does your child get along with other children?

☐ Poor ☐ Fair ☐ Average ☐ Very Well

74. Describe your child's interactions with peers:

- ☐ No friends ☐ Few friends ☐ Loses friends ☐ Bossy, controlling
☐ Mean, aggressive ☐ Too shy, timid ☐ Trouble making new friends

75. Does your child currently smoke tobacco? ☐ Yes ☐ No

Would you like assistance for your child with either quitting or cutting down use?

- ☐ Yes ☐ No

76. Do any of your child's friends engage in risky behavior (for example, smoking, drug use, involvement with police)? ☐ Yes ☐ No

If yes, please explain_____

77. What, if any, religious denomination is your child? _____

How often does he/she attend religious services? _____

78.State whether the family has relocated, moved residence or changed significantly in lifestyle due to job or health-related factors such as promotions, unemployment, acute or chronic illness in family, military service, etc. _____

79. List the individuals, groups, or agencies you are involved with that relate to this child and his/her problems (examples: Church or church group, PTA, AA, Division of Family Services). _____

80. What do you see as your child's strengths? _____

81. What do you see as your child's weaknesses? _____

Please add any other information below that you feel is important in understanding your child.

[illegible]

Thank you for taking the time to complete this form.