COMMUNITY
PSYCHOLOGICAL SERVICE
University of Missouri—St. Louis

CHILD AND ADOLESCENT MEDICAL/DEVELOPMENTAL HISTORY

Please complete the following questionnaire as thoroughly as possible.

Child's Name:_____ Age: _____
Birth Date: _____ Gender: _____
Race/Ethnicity:_____ 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: _____ Grade:_____
Child's Teacher:_____ 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.

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

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:

Name	*Age*	*Living*	*Occupation*	*Health*
		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:

Parent's Name	*Date of Marriage*	*Date of Divorce*

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)

☐ None	☐ Diabetes	☐Premature Birth
☐High Blood Pressure	☐Cesarean Section	☐Poor Nutrition
☐Breech Birth	☐ Poor Emotional Health	☐ Toxemia
☐Jaundice	☐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 difficult 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:

Name of Person	*Age*	*Relationship to Child*	*From*	*Until*

Medical History

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

Operation/Hospitalization	*Age at Time*	*Problems/Aftereffects*

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

	Age		Age
☐ Vision (wears glasses, etc.)	____	☐ Hearing (hearing aids, etc.)	____
☐ Chronic ear infections	____	☐ Coordination (running, throwing, writing)	____

If yes, please describe:_____

_____

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

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

Illnesses/Persistent Conditions	*Age of Onset*	*Treatment*

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.

Accidents/Falls – what happened	*Age at Time*	*Treatment and aftereffects*

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

Current Medications	*Dosage*	*Reason Prescribed*	*Side effects*

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

Psychiatric 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

Name of Mental Health Professional	*Dates Seen*	*Reason for Treatment*

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

Name of Hospital	*Dates Seen*	*Reason for Treatment*

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_____
☐ Intellectual Disability_____
☐ 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

School Year	*Grade*	*Age*	*Name of School*	Passed/Retained	*Note any problems*

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:

Age	*By whom*	*What were the results?*

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:

Why	*For what type of class*	*Grade(s)*

62. Has your child ever been suspended or expelled? ☐ Yes ☐ No
If yes, please explain:

Grade	*Why*

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. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this form.