CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

IDENTIFYING INFORMATION

Date of Assessment: _____

Name of person completing assessment: _____ Relationship to Child: _____

Name of child: _____ Gender: (M) (F) Birth date: _____
Education (current grade): _____ School: _____ Teacher: _____
Religion (optional): _____ Place of Birth: _____ Age: _____
Name of Primary Care Physician: _____ Phone #:
_____

I give permission for Sandra Graves, LMFT to contact the child's physician/teacher/etc. regarding treatment issues, symptoms, behaviors, or other information necessary for the treatment of said minor patient.
Parent signature: _____ Date: _____

CHIEF COMPLAINT: Presenting Problems: (check all that apply)

_Very unhappy
_Impulsive
_Irritable
_Stubborn
_Temper outbursts
_Disobedient
_Withdrawn
_Infantile
_Daydreaming
_Mean to others
_Fearful
_Destructive
_Clumsy
_Trouble with the law
_Overactive
_Running away
_Slow
_Self-mutilating
_Short attention span
_Head banging
_Distractible
_Rocking
_Lacks initiative
_Shy
_Undependable
_Strange behavior
_Peer conflict
_Strange thoughts
_Phobic
_Exploitive
_Fire setting
_Stealing
_Lying
_Sexual trouble
_School performance
_Truancy
_Bed wetting
_Soiled pants
_Eating problems
_Sleeping problems
_Sickly
_Drugs use
_Alcohol use
_Suicide talk
_Physically aggressive
_Emotional meltdowns
_Isolating

How long have these problems occurred? (number of weeks, months, years): _____
What happened that made you seek help at this time? _____
_____
Problems perceived to be: _not serious _very serious _serious
How does the problem affect the child and the family? _____
_____
What are your expectations of your child? _____
_____ Are your expectations realistic for your child? _ Yes _ No
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? _____

Is the client currently taking any medication? If "yes", what, how much. Use back side of page if needed.
Medication name:_____ Dose:_____ Reason for medication: _____
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Medication name:_____ Dose:_____ Reason for medication: _____

Name of Prescribing Physician: _____

PSYCHOSOCIAL HISTORY & CURRENT FAMILY SITUATION:

Mother—Relationship to child: _natural parent _relative _step-parent _adoptive parent
Marital status: _married _separated _divorced _deceased number of previous marriages _____
Occupation: _____ Highest level of education completed:
_____
Birthplace: _____ Age: _____Religion:
_____

Father—Relationship to child: _natural parent _relative _step-parent _adoptive parent
Marital status: _married _separated _divorced _deceased number of previous marriages _____
Occupation: _____ Highest level of education completed:
_____
Birthplace: _____ Age: _____Religion: _____

Who is the primary disciplinarian in the home?_____
What form does discipline/consequences usually take? __ loss of privileges __ spanking/corporal punishment
__ time outs __additional chores __other: _____

If child is adopted:
Name adoption source: _____
Reason and circumstances: _____
Age when child first in home: _____
Date of legal adoption: _____
What has the child been told? _____

LIVING ARRANGEMENTS: Places Dates

Number of moves in child's life: _____ _____
_____
_____
_____
_____
_____
_____
_____

Presently living in a: _House _ Condo _Apartment _Other: _____
Names and relationship to child of other adults living in the home: Age: Relationship to child/family:
1._____ _____ _____
2._____ _____ _____
3._____ _____ _____
4._____ _____ _____
Does the child share a room with anyone else? _Yes _No
If, yes, with whom? _____ If no, how long has he/she had own room? _____
Was the child ever placed, boarded, or lived away from the family? _Yes _ No If yes, please explain:_____

_____

What are the major family stressors at the present time, if any? _____
_____

BROTHERS and SISTERS (indicate if child is a half-sibling or step-sibling) :

Name: Age: Gender:

1._____ _____ _____
2._____ _____ _____
3._____ _____ _____
4._____ _____ _____
5._____ _____ _____
6._____ _____ _____

FAMILY HISTORY

Does any member of the child's family have an alcohol/substance abuse problem? Yes No If yes, how are they related to the child? _____
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: _mental retardation, _epilepsy, _birth defects, _schizophrenia, _depression? (If yes, please explain): _____

CHILD HEALTH INFORMATION: Note all health problems the child has had or has now.

_High fevers
_Pneumonia
_Encephalitis
_Meningitis
_Convulsions
_Unconsciousness
_Concussions
_Head Injury
_Fainting
_Dizziness
_Tonsils Removed
_Vision Problems
_Hearing Problems
_Earaches
_Dental Problems
_Weight Problems
_Allergies
_Skin Problems
_Asthma
_Headaches
_Stomach Problems
_Accident Prone
_Anemia
_High or Low Blood Pressure
_Sinus Problems
_Heart Problems
_ Hyperactivity

Other Illnesses, please explain: _____
Has the child ever been hospitalized? _Yes _No If yes, please explain (age, how long, reason):_____
_____
Has child ever been seen by a medical specialist? _Yes _No If yes, please explain (age, how long, reason): _____
_____
Has child been on any medications in the past that had problematic side-affects? _Yes _No If yes, please explain:
_____
When did last child have a full physical exam?: _____

DEVELOPMENTAL HISTORY:
PRENATAL: Did mother have prenatal care? _Yes _ No Was child wanted? _Yes _No Planned for? _Yes _No
Normal pregnancy? _Yes _No If mother was ill or upset during pregnancy, explain: _____
_____
Full term? _Yes _No Did mother have paternal support and acceptance : _Yes _No If no, please explain: _____
_____
Did mother use alcohol or illegal substances during pregnancy? _Yes _ No If yes, explain: _____
_____

BIRTH:
Length of active labor: ____ hours, Delivery was _Easy _Difficult If premature, how early: _____ weeks

Birth weight: lbs__ oz__ Type of delivery: _spontaneous _cesarean _head first _breech
Was it necessary to give the infant oxygen? _Yes _ No Did infant require blood transfusions? _Yes _No
Did infant require X-ray? _Yes _No Did infant test positive for drugs at birth? _Yes _No
Physical condition of infant at birth: _____

NEWBORN PERIOD: Did the child suffer from any of the following as an infant?

_irritability _convulsions/twitching _failure to thrive
_vomiting _colic
_difficulty breathing _underweight
_difficulty sleeping _overweight

DEVELOPMENTAL MILESTONES: Age at which child (in months and years):

Weaned off bottle/breast _____ Walked _____ Bladder trained _____
Sat up _____ Spoke single words _____ Bowel trained _____
Crawled_____ Spoke sentences _____
Describe the manner in which toilet training was accomplished:_____

EARLY SOCIAL DEVELOPMENT:
Behaviors during early years: __Usually played alone __Played well in groups __Cooperative __ Competitive
__Usually the leader in a group __Usually a follower in a group __Poor social skills/less mature than same-age peers
Describe special habits, fears, or idiosyncrasies of the child: _____

EDUCATIONAL HISTORY: Last grade completed ___ So far, how many different schools has your child attended?___
Types of classes: _regular _advanced _special education
Did child skip a grade? _Yes _No Repeat a grade? _Yes _No If yes, explain _____
_____
Does child have any specific learning difficulties? _Yes _No If yes, explain: _____
Has child ever have a tutor for 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 grade on last report card? ____ Lowest grade on last report card? ____ Favorite subject?
_____
Least favorite subject? _____ Does child participate in extracurricular activities? __Yes __No
If yes, please list activities/sports _____
In school, how many friends does child have: __a lot __a few __ one good friend __none
What are your 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: _____

JUVENILE JUSTICE SYSTEM INVOLVEMENT
Has the child ever had difficulty with law enforcement? _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 If yes, for what reason? _____
Has child ever been employed? _Yes _No If yes, employed as what and for how long? _____
Has child ever been a victim of __ physical abuse __sexual abuse /rape __witness to domestic violence
__emotional/verbal abuse __exposure to pornography If so, pleases explain: _____

BEHAVIORAL TRAITS: Please check below any of the behaviors that apply to your child

_Affectionate
_Argues, "talks back," smart-alecky, defiant
_Blames others for his/her mistakes
_Bullies, intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes, calls others names/belittles others
_Cheats
_Cruel to animals
_Conflicts with parents over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
_Complains often
_Cries easily, feelings are easily hurt
_Dawdles, procrastinates, wastes time
_Difficulties with parent's new marriage/new partner/new family
_Dependent, immature
_Developmental delays
_Disobedient, uncooperative, noncompliant, doesn't follow rules
_Disrupts family activities
_Distractible, inattentive, poor concentration, daydreams, slow to respond
_Dropping out of school
_Drug or alcohol use
_Easy-going personality
_Eating problems (refuses most foods, unusual appetite increase or decrease, odd combinations, frequently overeats)
_Eats non-food materials (such as dirt or paper)
_Exercise problems
_Extracurricular activities interfere with academics
_Failure in school
_Fearful
_Fighting, hitting, violent, aggressive, hostile, threatens, destructive
_Fire setting
_Frequent emotional “meltdowns”
_Frequently irritable
_Friendly, outgoing, social
_Hypochondriac, always complains of feeling sick
_Immature, "clowns around”, has only younger playmates
_Imaginary playmates, fantasy
_Independent
_Inflexible
_Interrupts, talks out, yells
_Is kind to others
_Is stubborn/willful
_Lacks organization skills, frequently unprepared
_Needy, requires much more attention than same-age peers or siblings
_Passive and gets pushed around
_Plays the “class clown”
_Poor manners
_Problems with authority figures/disrespectful
_Seldom affectionate
_Sexually inappropriate
_Shows concern for others/empathetic
_Shows little or no remorse for actions
_Takes responsibility for own actions
_Trouble waiting his/her turn
_Vocal tics

Please write below any other information about your child/family that you feel would be important to know: