michigan school psychological clinic

power to grow

Child and Adolescent History Form

The information requested in this form is treated as CONFIDENTIAL. The questions are designed to help us understand your concerns about your child or adolescent, so that we are able to assist you. If you have any questions about the requested information, please do not hesitate to ask.

Child/Adolescent Name _____ Date _____

Date of Birth _____ Age_____ Grade_____

Address _____ City _____ Zip Code _____

Parent/Guardian (A) Name _____ Phone # _____

Parent/Guardian (B) Name _____ Phone # _____

Are the above named the child/adolescent's: ☐ Biologic Parent(s) ☐ Adoptive Parent(s) ☐ Stepparent

Other General Family Information

Is the child/adolescent adopted? ☐ No ☐ Yes

If yes, at what age were they adopted? _____ If yes, do they know of the adoption? _____

Please list all persons living in the home with the child/adolescent whom we will be evaluating:

Names of Current Residents	Age	Relationship to Child/Adolescent

Are the child/adolescent's parents separated or divorced? ☐ No ☐ Yes If yes, please answer the following:

When did the separation occur (month/year)? _____

When was the divorce final (month/year)? _____

Who has legal custody? _____

Who has physical custody? _____

Does the noncustodial parent:

□ Know of this Evaluation □ Have Regular/Frequent Contact with Child/Adolescent

□ Have Limited/Unpredictable Contact □ Insure the Child/Adolescent

If the child/adolescent **does not** live with biological or adoptive parent(s), please provide the following information regarding your guardianship.

Are you:

□ A Foster Parent(s)

□ A legal guardian(s) who is a biologic relative: State relationship _____

□ A legal guardian(s) who is not a biologic relative

Foster Parent/Guardian's Name _____

Please state why child/adolescent is in foster care or with a guardian _____

_____

Please state the problem(s) your child/adolescent is experiencing that led you to seek help: _____

_____

_____

_____

_____

Did anyone suggest/require you to seek help for your child/adolescent? □ No □ Yes If yes, who and for what reason(s) if different from above reason: _____

_____

General Behavior

Please check any items below which describe your child/adolescent's typical behavior. That is, how they are **most of the time:**

□ Friendly, Outgoing	□ Prefers Company	□ Cooperative	□ Respectful
□ Shy	□ Prefers to be Alone	□ Stubborn	□ Defiant
□ Easygoing, Calm	□ Optimistic	□ Confident	□ Takes Risks
□ Irritable	□ Pessimistic	□ Expects Failure	□ Cautious
□ Hardworking	□ Caring	□ Sharing	□ Generally Happy
□ Lazy	□ Uncaring	□ Selfish	□ Generally Unhappy

Problem Behaviors

Please check any of the behaviors which occur **excessively or frequently now and/or in the past:**

☐ Worries	☐ Skipping Classes/School	☐ Reckless/Careless Behavior	☐ Mood Swings
☐ Fears	☐ Legal Problems	☐ Disruptive Behavior	☐ Sadness
☐ Obsessive Thoughts	☐ Runs Away from Home	☐ Messy	☐ Depression
☐ Compulsive/Repetitive Behavior		☐ Tantrums/ Angry Outbursts	
☐ Crying Spells	☐ Bullies	☐ Short Attention Span	☐ Irritable
☐ Odd Thoughts	☐ Argues	☐ Distractible	☐ Withdrawn
☐ Odd Behavior	☐ Defiant/Oppositional	☐ Impulsive	☐ Boredom
☐ Disturbing Thoughts	☐ Fights	☐ Hyperactive	
☐ Nightmares	☐ Lies	☐ Learning Problems	
☐ Night Terrors	☐ Steals	☐ Speech Problems	
☐ Insomnia	☐ Destroys Property	☐ Poor School Work	
☐ Sleepwalking	☐ Sets Fires	☐ Sexual Activity	
☐ Will Not Sleep Alone	☐ Cruelty to Animals	☐ Accident Prone	
☐ Missing School Due to Illness		☐ Significant Appetite	
☐ Frequent Physical Complaints			

Has your child/adolescent ever talked about or attempted suicide? ☐ No ☐ Yes If yes, when and what were the circumstances? _____

_____

_____

Has your child/adolescent ever talked seriously about hurting or killing someone/something, or done so? ☐ No ☐ Yes If yes, when and what were the circumstances? _____

_____

_____

To your knowledge, has your child/adolescent ever been physically abused? ☐ No ☐ Yes If yes, when and what were the circumstances? _____

_____

_____

Has your child/adolescent ever been the victim of sexual abuse? ☐ No ☐ Yes If yes, please explain.

_____

_____

Has your child/adolescent ever used alcohol and/or drugs? ☐ No ☐ Yes If yes, please be sure to complete the substance abuse questions in the last section of this history form.

Birth to Five Year Developmental History

Mother's Pregnancy ☐ Normal ☐ Complicated Explain: _____

_____

Check any substances the biologic mother used during her pregnancy and comment on any item checked:

☐ Tobacco ☐ Alcohol ☐ Drugs ☐ Medications

_____

_____

Check any of the following that pertains to the biologic mother's delivery:

☐ Full Term ☐ Vaginal Delivery ☐ Premature ☐ C-Section ☐ Fetal Distress

Please explain any complications: _____

_____

Child's condition at birth: ☐ Normal ☐ Abnormal If abnormal, please explain: _____

_____

As an infant, was your child/adolescent:

☐ Easy to Manage ☐ Irritable ☐ Demanding

☐ Alert/Responsive ☐ A Poor Eater ☐ A Poor Sleeper

At what age did your child:

Sit up unassisted _____ Walk without support _____ Use first words _____

Use sentences _____ Toilet trained for daytime _____ Dry at night _____

Was toilet training easy or difficult? ☐ Easy ☐ Difficult

Does your child/adolescent ☐ Bed wet ☐ Daytime wet ☐ Soil and/or has bowel movements in underclothing

Please comment on any checked item: _____

By or before the time your child entered kindergarten, did you, your child's physician, or any of your child's preschool teachers have concerns about any of the following areas of development?

☐ Language Development (Use of words & sentences) ☐ Balance/Coordination ☐ Vision

☐ Speech Development (Pronunciation) ☐ Behavior Problems ☐ Intelligence

☐ Fine Motor Development (pencil grip, coloring, cutting, etc.) ☐ Hearing

School History

Current School: _____ Phone: _____

Address: _____ Zip Code: _____

Has your child/adolescent ever repeated a grade? ☐ No ☐ Yes If yes, which grade(s) and why? _____

_____

_____

Has your child/adolescent ever been assessed for Special Education services? □ No □ Yes

If yes, when? _____

Is your child/adolescent receiving Special Education services now? □ No □ Yes

If yes, what type of Special Education? _____

Was your child/adolescent in Special Education in past years? □ No □ Yes

If yes, when and what type of Special Education were they certified to receive? _____

_____

Family Culture and/or Ethnic Information

As a family, do you identify yourself with a particular cultural or ethnic group? □ No □ Yes If yes, please note cultural/ethnic identification and the influence or role it plays in family life: _____

_____

_____

Religious and/or Spiritual Information

Do you regularly attend church as a family? □ No □ Yes

What is the religious/spiritual orientation of your family? _____

How does your religious/spiritual orientation affect family life? _____

_____

Social/Recreational/Study Time Information

How many hours per week does your child/adolescent spend in social/leisure time activities? _____

Is your child/adolescent involved in any organized sports or recreational activities? □ No □ Yes If yes, please note what activities and how many hours per week: _____

How many hours per week does your child/adolescent study and/or do homework? _____

Sexual Information

To your knowledge, is your adolescent sexually active? □ No □ Yes If yes, please explain: _____

_____

As the parents or guardians, do you have any specific concerns regarding sexual matters (i.e. educational, sexual behavior of adolescent, sexual orientation of child/adolescent, etc.)? □ No □ Yes If yes, please state your concerns:

_____

_____

_____

_____

Adolescent Work History

Did/does your adolescent hold a job? □ No □ Yes If yes, please list their employment history below beginning with the current or most recent job, and work back through their job history.

Employer **Dates** **Job Description**

_____

_____

_____

Has your adolescent experienced any work related problems? □ No □ Yes If yes, please explain: _____

_____

_____

Legal Information

Is your child/adolescent involved in any civil or legal proceedings? □ No □ Yes If yes, please explain: _____

_____

Has your child/adolescent ever been charged/arrested for any offense in which drugs or alcohol been involved?
□ No □ Yes If yes, please explain: _____

_____

Is your child/adolescent presently on probation? □ No □ Yes If yes, please explain: _____

_____

Does your child/adolescent have any history of the following? □ No □ Yes If yes, check any that applies and explain below.

□ Suspended/revoked driver's license □ DUI/DWI □ Minor in possession of alcohol/drugs

□ Conviction of misdemeanor □ Conviction for felony □ Shoplifting

□ Other: _____

Explanation: _____

_____

Significant Life Events

Please check any of the following events which have occurred in your child/adolescent's life and their age when it occurred.

Event or Situation	Age	Event or Situation	Age
☐ Change of residence	_____	☐ Family gambling problems	_____
☐ Change of schools	_____	☐ Family psychiatric problems	_____
☐ Change of custody	_____	☐ Family chronic illness	_____
☐ Marital conflict	_____	☐ Other family problems	_____
☐ Parents separated	_____	☐ Rejection by family member(s)	_____
☐ Parents divorced	_____	☐ Abuse to self (verbal, physical, sexual)	_____
☐ Parent visitation problems	_____	☐ Witnessed abuse to others	_____
☐ Post divorce parent conflict	_____	☐ Victim of abuse	_____
☐ Parent(s) remarried	_____	☐ Suffered/witnessed significant accident or injury	_____
☐ Step parent problems	_____	☐ Other severe fright or trauma	_____
☐ Sibling birth	_____	☐ Death of family member or friend	_____
☐ Acquired step sibling(s)	_____	☐ Suicide of family member or friend	_____
☐ Family economic problems	_____	☐ Death of pet	_____
☐ Family job problems	_____	☐ Other_____	_____
☐ Family substance abuse	_____		

Previous Psychiatric and/or Chemical/Dependency Treatment History

Has your child/adolescent received any psychiatric or chemical dependency of treatment in the past?

☐ No ☐ Yes If yes, please indicate in the space provided below.

Type of Treatment	Dates	Treatment Facility & Therapist
Outpatient Psychiatric	_____	_____
	_____	_____
Inpatient Psychiatric	_____	_____
	_____	_____
Outpatient Chem. Dependency	_____	_____
	_____	_____
Inpatient Chem. Dependency	_____	_____
	_____	_____

Family Psychiatric & Substance Use History

Please check any family members with a history of difficulties in the areas noted.

Relationship	Chronic Medical Problems	Neurologic Disorders	Seizure Disorder	Thyroid Disorder	Mental Retardation
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐
Other Relatives	☐	☐	☐	☐	☐

Please make any additional comments you feel might be relevant regarding family members' psychiatric, chemical substance abuse, or medical history.

_____

_____

_____

_____

Medical History

Are your child/adolescent's immunizations current? ☐ Yes ☐ No ☐ Unsure

Date of most recent physical _____ Results: ☐ Normal ☐ Other (explain)

_____

_____

What is your child/adolescents current: Height _____ Weight _____

Is your child/adolescent currently taking any medication(s)? ☐ No ☐ Yes If yes, please list name of medications and daily dosage:

_____

_____

_____

Has your child/adolescent been hospitalized for medical treatment? ☐ No ☐ Yes If yes, when and for the treatment of what condition:

_____

_____

_____

Please provide the following information about your child/adolescent's physician

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

Substance Abuse History

This section is to be completed if the client to be seen has a history or suspected history of substance abuse.

Please list any chemical substance you know, or suspect, your child/adolescent has taken.

Name of substance	Age when use was discovered or suspected
_____	_____
_____	_____

Check those items that apply to your knowledge of your child/adolescent. While many apply directly to substance use, please keep in mind that substance abuse is only one possible explanation for the behavioral changes noted.

- □ Witnessed intoxication/high
- □ Found alcohol (e.g. empty or partially empty bottles, alcohol missing from the home)
- □ Found drugs in or outside of the home in their possession
- □ Alcohol/drug use reported by neighbors, friends, or a family member
- □ Reports of alcohol/drug use by school personnel
- □ Report of alcohol/drug use by the police
- □ Found drug paraphernalia
- □ Significant negative change in personality
- □ Extreme, irrational mood swings
- □ Extreme isolation/withdrawal from family
- □ Increased conflict/tension with family members
- □ Increased conflict/tension with peers
- □ A decrease in school grades, attitude and motivation
- □ Decreased interest in hobbies, sports, and recreation
- □ A change in peer group or tendency to keep friends a secret
- □ Missing money or valuable from the home and/or stealing outside the home

Relationship of Adult Completing Form to the Child/Adolescent to be seen in Clinic:

□ Parent □ Foster Parent □ Guardian □ Other: _____

_____

Signature of Adult Completing Form Date

_____

Signature of Clinician Reviewing Form Date