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Child, Adolescent, and Adult Psychiatry

Please complete this form and bring it with you to your child's appointment. Feel free to use additional paper if needed.

I. CHILD AND FAMILY BACKGROUND INFORMATION

A. Child

Child's Name ____

Sex ________ Race ______________________ Date of Birth ______________________

Legal Guardian ____

Is child: by birth / adopted / step / foster (please circle)

B. Family

1. Father's Name ____

Age ______________ Occupation ______________________________

Is he living? ________________ Is he living with child? ______________________

2. Mother's Name ____

Age ______________ Occupation ______________________________

Is she living? ________________ Is she living with child? ______________________

3. Are the child's parents currently living together? ______________________________

If no: a) Date of separation ______________________ child's age ______________________

b) Date of divorce ______________________ child's age ______________________

4. Siblings (please list)

Name	Age	Sex	Place where living

5. Adults living in child's current home (other than listed above)

Name	Age	Sex	Relationship to child

6. Other children presently living in child's current home (other than listed above)

Name	Age	Sex	Relationship to child

7. Have there been recent major changes or stresses in your child's life?
If yes, please describe:

II. YOUR CONCERNS ABOUT YOUR CHILD

A. What concerns do you have about your child that resulted in your seeking a psychiatric evaluation at this time?

B. How long have these problems existed?

C. Have you sought previous psychological evaluation/treatment for your child?

1. Outpatient Professional/Agency — Date

______________________________ ________

______________________________ ________

______________________________ ________

2. Inpatient Hospital — Date

______________________________ ________

______________________________ ________

D. Have any of your other children had emotional, behavioral, learning, or chronically handicapping problems? If yes, list sibling and problem:

III. CHILD'S MEDICAL HISTORY

	Yes	No	Describe
1. Did mother have any medical problems during pregnancy? (e.g. bleeding infection, high blood pressure, etc.)	____	____	______________________
2. Did the mother take medications during pregnancy?	____	____	______________________
3. Did the mother use alcohol or drugs during pregnancy?	____	____	______________________
4. Was yourchild premature?	____	____	______________________
5. Birth weight			______________________
6. Were there any problems during labor and delivery?	____	____	______________________
7. Did your child have problems during newborn period?	____	____	______________________

8. Was your child difficult to care for during the first year? ____ ____ ______________________

9. Has your child had any severe illness or repeated or chronic medical problems? (e.g. earaches, infections, etc.)

Illness/Problem	Age	Treatment
____________	____	____________
____________	____	____________
____________	____	____________

	Yes	No	Describe
10. Has your child had any serious accident or injuries? (especially head injury or unconsciousness)	____	____	______________________
11. Has your child ever been on medication for behavior or emotional problems?	____	____	______________________
12. Is your child on any medication now?	____	____	______________________

Medication	Dose	Purpose	Effect
________	________	________	________
________	________	________	________
________	________	________	________

	Yes	No	Describe
13. Is your child allergic to any medication?	____	____	______________________
14. Dose your child have any other allergies?	____	____	______________________
15. Does your child have any visual or hearing problems?	____	____	______________________
16. Is there anything else about your child's health that concern you?	____	____	______________________

IV CHILD'S DEVELOPMENTAL HISTORY

1. Does your child have any eating problems? ____ ____ ______________________
2. Does your child have any sleeping problems? ____ ____ ______________________
3. At what age did your child:
   a. Sit alone ____
   b. Walk alone ____
   c. Speak real words ____

d. Speak sentences ____

e. Achieve day bladder training ____

f. Achieve day bowel training ____

g. Achieve night training ____

h. Write alphabet ____

i. Read words ____

j. Ride a bike ____

k. Tie shoelaces ____

4. Please rate your child's progress in the following areas of development:

	Slow	Average	Fast
a. Speech and Language	____	____	____
b. Gross Coordination (run, walk, sports)	____	____	____
c. Fine Coordination (write, draw)	____	____	____
d. Socializing	____	____	____

5. While your child was growing up did you notice any difficulties in these areas:

	Yes	No	Describe
a. Discipline	____	____	________________________________
b. Temper tantrums, fighting	____	____	________________________________
c. Moods	____	____	________________________________
d. Relationships with peers	____	____	________________________________
e. Relationships with adults	____	____	________________________________
f. Sex play	____	____	________________________________
g. School problems	____	____	________________________________
h. Fears or phobias	____	____	________________________________
i. Other behavioral problems	____	____	________________________________

V. CHILD'S TEMPERAMENT

1. Is your child overactive?	____	____	________________________________
2. Does your child have trouble paying attention?	____	____	________________________________
3. Does you child have trouble staying with one	____	____	________________________________
activity, jumping from one thing to another			________________________________
or failing to finish things?			________________________________
4. Does your child fluctuate quickly from happy	____	____	________________________________
to angry with little apparent cause?			________________________________

5. Does your child become easily frustrated? ____ ____ ____________________

6. Does your child become upset with abrupt changes? ____ ____ ____________________

7. Are your child's emotional responses unpredictable? ____ ____ ____________________

8. Does it take your child a long time to warm up to new situations or people? ____ ____ ____________________

9. Is your child unusually sensitive or insensitive to pain?____ ____ ____________________

10. Does your child react strongly to things? ____ ____ ____________________

IV. SCHOOL AND SCHOOL EXPERIENCES

A. School

1. Present School ______________________________

2. Grade level _________ Type of class______________________________

3. Approximate days missed this school year ______________________________

4. Has your child ever been suspended or expelled from school? ____________________

If yes, please give date and reason. ______________________________

5. Has your child ever repeated a grade? _______ If yes, which grade? ____________________

6. Has your child ever skipped school? _______ If yes, how often? ____________________

7. Has your child ever been fearful or reluctant to go to school? _______ If yes, which grade?___________

8. Does your child do homework regularly? ______________________________

9. Does your child like his/her teacher? ______________________________

10. Do you think your child is doing well in school? ______________________________

11. Has your child ever received comprehensive educational testing? ____________________

B. Social

1. Does your child prefer to play with others ____ or alone ____?

2. How does your child get along with others his/her age?

Poor ___ Fair ____ Average ____ Very Well ____

3. What age companion does your child prefer? ____

4. What activities does your child enjoy with other children?

VII CHILD'S FAMILY HISTORY (Parents, grandparents, siblings, aunts, uncles)

Has anyone had the following?

	Yes	No	Describe
1. Neurological disease such as seizures, weakness etc?	____	____	____________________
2. Medical disease such as diabetes, heart disease, etc?	____	____	____________________

	Yes	No	Describe
3. Mental illness such as depression, schizophrenia, etc?	____	____	____________________________________
4. Mental retardation?	____	____	____________________________________
5. Learning problems?	____	____	____________________________________
6. Behavioral problems?	____	____	_____________________________
7. Excessive alcohol use?	____	____	____________________________________
8. Excessive drug use?	____	____	____________________________________
9. Trouble with the law?	____	____	____________________________________

VIII SUMMARY

1. Do you have any ideas why your child is having problems now?

2. What are your child's strengths?

Include copies if individual education plans (I.E.P.), school/psychological testing and report cards for this child.