

CHILD/ADOLESCENT COMPREHENSIVE HISTORY

Child's Name _____

Child's Birth Date _____

Child's Address _____

Child's School and Grade _____

Father's Name and DOB _____

Mother's Name and DOB _____

Stepfather's Name and DOB _____

Stepmother's Name and DOB _____

Siblings' Names and Dates of Birth _____

Phone Numbers (home/work/cell) _____

Other address _____

Other persons residing in the home

DEVELOPMENTAL HISTORY

Was the pregnancy planned?

If there were any complications during the pregnancy, please explain:

Was mother under emotional stress during the pregnancy? Please explain:

Did mother use: Drugs, Alcohol, Tobacco or Medications?

If yes to any of the above, please give the type, amounts used, and frequency during the pregnancy:

Was mother involved in prenatal care?

Birth weight of child:

Any difficulties with the birth? Please explain:

Did your baby have to stay in the hospital after the birth? Please explain:

For the next questions if you do not remember an approximate time, please circle *Before or After?*

When did your child walk?	Before	After	one year?
Say his/her first word?	Before	After	one year?
Talk in sentences?	Before	After	three years?
Complete toilet training?	Before	After	three years?

Were there any speech problems?

Has your child had speech therapy?

Were there early difficulties during infancy with:

Feeding___ Sleeping___ Colic___ Head banging___ Excessive Rocking___

Were there any early problems (before age 7) with:

Nightmares____ Night terrors____ Bed wetting____ Messing pants____
Unusual fears____ Aggression____ Temper tantrums____ Hyperactivity____
Difficulties with impulse control____ Inability to pay attention____ Problems with other
children____ Being a dare devil____ Having no fear____ Being bold____ Being
demanding____ Being overly sensitive____

If yes to any of the above early childhood problems, please explain:

Significant medical problems for child:

For the following questions, please indicate dates and how long the abuse lasted.

Has your child ever been physically abused?

Sexually abused?

Mentally/emotionally abused?

Please list positives about your child (e.g., good with children, athletic, musical, etc.)

What does your child like to do for fun?

Please list your expectations concerning the outcome of therapy for your child:

SCHOOL

Has your child experienced any difficulties in school - academic or behavioral?

Has your child been suspended or expelled from school? Please explain:

Does your child have a learning disability? Please explain:

How would you describe your child's overall school performance?

ENVIRONMENTAL STRESSORS

Have there been major changes or events in your child's or family's life?

Death of friend or family member:

Moves:

Ill health of family member:

Financial problems:

Addiction in family:

Violence in family:

Other:

CHILD'S PAST MENTAL HEALTH OR PSYCHIATRIC HISTORY

Counselor Name:

Reason for Counseling:

Dates of Counseling:

Please list the condition or diagnosis and any medications prescribed with dates, dosages, and who prescribed them.

Example: ADHD Ritalin 5 mg Dr. Jones 2001-2002

FAMILY HEALTH HISTORY

Have any of your child's biological relatives (brothers, sisters, mother, father, aunts, uncles, and grandparents) suffered from any of the following conditions?

Please specify family member and whether it is paternal or maternal:

Depression

Drug/Alcohol problems

Hyperactivity (ADD/Attention problems)

Schizophrenia

Bipolar Disorder

Anxiety/Panic

Violent behavior

Suicidal behavior

Physical abuse

Sexual abuse

Obsessive-Compulsive behavior

Learning disability