Child/Adolescent Psychosocial

Name of Child:_____ Date:_____

CHIEF COMPLAINTS:

Presenting Problems (check all that apply):

_____Affectionate
_____Argues, talks back
_____Bullies, intimidates
_____Cheats
_____Cruel to animals
_____Concern for others
_____Conflicts with parents
_____Complains
_____Cries easily
_____Procrastinates
_____Difficulty with new family
_____Dependent, immature
_____Developmental delays
_____Disrupts family activities
_____Disobedient, uncooperative
_____Distractible, inattentive
_____Dropping out of school
_____Drug or alcohol use
_____Eating problems
_____Exercise Problems
_____Extracurricular activities
_____Failure in School
_____Fearful
_____Fighting, hitting, violent
_____Fire setting
_____Friendly, outgoing, social
_____Frequent complains (illness)
_____Immature, clowns around
_____Imaginary playmates, fantasy
_____Independent
_____Interrupts, talks out, yells
_____Lacks organization
_____Lacks respect for authority
_____Learning difficulties
_____Legal difficulties
_____Likes to be alone, isolates, withdraws
_____Lying
_____Low frustration tolerance, irritability
_____Mental retardation
_____Moody
_____Mute, refuses to speak
_____Nail biting
_____Nervous
_____Nightmares
_____Need for high supervision
_____Obedient
_____Obesity
_____Overactive, restless, hyperactive
_____Oppositional, resists, refuses
_____Prejudiced, insulting, name calling
_____Pouts
_____Recent move, new school
_____Poor relationships with siblings
_____Poor relationships with peers
_____Responsible
_____Rocking or repetitive movements
_____Runs away
_____Sad, unhappy
_____Self-harming behaviors
_____Speech difficulties
_____ Sexual (inappropriate)
_____Shy, timid
_____Stubborn
_____Suicide talk or attempt
_____Swearing, blasphemes
_____Temper tantrums, rages
_____Thumb sucking
_____Tics (involuntary movements)
_____Teased, picked on, victimized
_____Truant, school avoiding
_____Underactive, lethargic
_____Uncoordinated, accident prone
_____Wetting or soiling bed or clothes

Explain (if needed):

How long have these problems occurred? (number of weeks, months, years?)

_____

What happened that makes you seek help at this time?

_____

_____

Problems perceived to be: _____very serious _____serious _____not serious

What are your expectations of your child?

_____

_____

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?

_____

_____

PSYCHOSOCIAL HISTORY:

CURRENT FAMILY SITUATION:

Mother-Relationship to child _____natural parent _____relative

_____step-parent _____adoptive parent

Occupation:_____

Education:_____ Religion:_____

Birthplace:_____ Birthdate:_____

Age:_____

Father-Relationship to child _____natural parent _____relative

_____step-parent _____adoptive parent

Occupation:_____

Education:_____ Religion:_____

Birthplace:_____ Birthdate:_____

Age:_____

Marital History of Parents:

Natural Parents: _____married when _____

_____separated when _____

_____divorced when _____

_____deceased M or F_____

Step-parents: _____married when_____

LIVING ARRANGEMENTS:

Number of moves in child's life:_____

Does the child share a room with anyone else?: _____Yes _____No

If yes, with whom?:_____

Was the child ever placed, boarded, or lived away from the family? _____Yes _____No

Explain:_____

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

_____

What are the sources of family income?_____

_____

BROTHERS & SISTERS: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School Or Occupation	Present Grade	Living at home	Use drugs or alcohol (yes or no)	Treated for drug abuse (yes or no)
1.							
2.							
3.							
4.							
5.							

Others living in home (and their relationship):

1._____

2._____

Describe any family history of physical or mental illness:

_____

_____

_____

CHILD HEALTH INFORMATION:

Please note all health problems the child has had or has now. Indicate age:

_____

_____

_____

Has the child ever been hospitalized? _____Yes _____No

Has the child ever taken or is he/she currently taking any prescribed medications?

_____Yes _____No

Prescribed Medications:

Age_____ How long?_____ Reason_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Name of primary care physician:_____

DEVELOPMENTAL HISTORY:

Prenatal- Child wanted? ____Yes _____No Planned for? _____Yes _____No

Normal preganancy? ____Yes _____No

If mother ill or upset during pregnancy, explain: _____

_____

Length of pregnancy:_____

Did mother use alcohol or drugs during pregnancy?: ____Yes _____No

EDUCATIONAL HISTORY:

Has the child had any specific learning difficulties? ____Yes _____No

Does the child attend school on a regular basis? ____Yes _____No

Has the child ever been suspended or expelled? ____Yes _____No

Highest grade on last report card?_____

Lowest grade on last report card?_____

Does the child participate in extracurricular activities? ____Yes _____No

Explain:_____

In school, how many friends does the child have? _____a lot _____a few _____none

Has the child had testing in school?

Psychological ____Yes _____No Vocational ____Yes _____No

Please lists our child's special interests, hobbies, skills:

_____

_____

Has the child ever had difficulty with the police?____Yes _____No

Has the child ever been on juvenile probation? ____Yes _____No

Has the child ever been employed? ____Yes _____No

ADDITIONAL COMMENTS:

_____

_____

_____

_____