

Child/Adolescent Psychosocial

Name of Child: _____

Date: _____

CHIEF COMPLAINTS:

Presenting Problems (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Imaginary playmates, fantasy | <input type="checkbox"/> Runs away |
| <input type="checkbox"/> Argues, talks back | <input type="checkbox"/> Independent | <input type="checkbox"/> Sad, unhappy |
| <input type="checkbox"/> Bullies, intimidates | <input type="checkbox"/> Interrupts, talks out, yells | <input type="checkbox"/> Self-harming behaviors |
| <input type="checkbox"/> Cheats | <input type="checkbox"/> Lacks organization | <input type="checkbox"/> Speech difficulties |
| <input type="checkbox"/> Cruel to animals | <input type="checkbox"/> Lacks respect for authority | <input type="checkbox"/> Sexual (inappropriate) |
| <input type="checkbox"/> Concern for others | <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Conflicts with parents | <input type="checkbox"/> Legal difficulties | <input type="checkbox"/> Stubborn |
| <input type="checkbox"/> Complains | <input type="checkbox"/> Likes to be alone, isolates, withdraws | <input type="checkbox"/> Suicide talk or attempt |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Lying | <input type="checkbox"/> Swearing, blasphemes |
| <input type="checkbox"/> Procrastinates | <input type="checkbox"/> Low frustration tolerance, irritability | <input type="checkbox"/> Temper tantrums, rages |
| <input type="checkbox"/> Difficulty with new family | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Dependent, immature | <input type="checkbox"/> Moody | <input type="checkbox"/> Tics (involuntary movements) |
| <input type="checkbox"/> Developmental delays | <input type="checkbox"/> Mute, refuses to speak | <input type="checkbox"/> Teased, picked on, victimized |
| <input type="checkbox"/> Disrupts family activities | <input type="checkbox"/> Nail biting | <input type="checkbox"/> Truant, school avoiding |
| <input type="checkbox"/> Disobedient, uncooperative | <input type="checkbox"/> Nervous | <input type="checkbox"/> Underactive, lethargic |
| <input type="checkbox"/> Distractible, inattentive | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Uncoordinated, accident prone |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Need for high supervision | <input type="checkbox"/> Wetting or soiling bed or clothes |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Obedient | |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Exercise Problems | <input type="checkbox"/> Overactive, restless, hyperactive | |
| <input type="checkbox"/> Extracurricular activities | <input type="checkbox"/> Oppositional, resists, refuses | |
| <input type="checkbox"/> Failure in School | <input type="checkbox"/> Prejudiced, insulting, name calling | |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Pouts | |
| <input type="checkbox"/> Fighting, hitting, violent | <input type="checkbox"/> Recent move, new school | |
| <input type="checkbox"/> Fire setting | <input type="checkbox"/> Poor relationships with siblings | |
| <input type="checkbox"/> Friendly, outgoing, social | <input type="checkbox"/> Poor relationships with peers | |
| <input type="checkbox"/> Frequent complains (illness) | <input type="checkbox"/> Responsible | |
| <input type="checkbox"/> Immature, clowns around | <input type="checkbox"/> Rocking or repetitive movements | |

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 pregnancy? ____ 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 list 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:
