Adolescent History Form
Up to age 16

Name ____ Age _____ Sex __ M __ F
Grade _____ School _______________________________________ Ethnicity/Race ____________

What event(s) or problems have caused you to seek treatment? ________________________________
____
____
____
____

Past Treatment:

- Has your child ever had any previous mental health treatment? __ Y __ N
  *If so please indicate which type and date/age at the time of treatment:
  Psychological Testing: Age ________ Date ____________________________
  Individual/Group/Family Therapy: Age ________ Date ____________________________
  Psychiatric Hospitalization: Age ________ Date ____________________________
  Residential Treatment: Age ________ Date ____________________________

What was the diagnosis? ____

- Is your child currently on any medications? __ Y __ N *Reason*

Please List: Medication ____________________________ Dosage __________________________
Medication ____________________________ Dosage __________________________
Medication ____________________________ Dosage __________________________
Medication ____________________________ Dosage __________________________

Have the above medications been effective? Please Explain: ______________________________
____
____

Symptoms: *Please check any that apply presently or have occurred in the past*

☐ Sleep Problems
☐ Nightmares
☐ Low Energy
☐ Concentration Problems
☐ Appetite Problems
☐ Bingeing/Purging
☐ Health Complaints
(eg. Headache, stomachache)
☐ Anger Problems
☐ Mood Swings
☐ Temper Tantrums
☐ Depressed Mood
☐ Anxiety/Worry/Panic
☐ Obsession/Compulsion
☐ Fears
☐ Oppositional/Defiant
☐ Behavior Problems at School
☐ Academic Problems
☐ Talk/Thoughts of Death
☐ Hurts Self or Others
☐ Harm to Animals
☐ Alcohol/Drug/Tobacco Use
☐ Sexual Acting Out
☐ Runaway

Child/Adolescent Assessment
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Medical History: *Please Rate your Child in each of the following areas*

	Good	Fair	Poor
Health	☐	☐	☐
Hearing	☐	☐	☐
Vision	☐	☐	☐
Gross Motor Coordination	☐	☐	☐
Fine Motor Coordination	☐	☐	☐
Speech Articulation	☐	☐	☐

Did your child experience prenatal exposure to alcohol, tobacco or drugs ☐ Y ☐ N
Has your child's physical development been normal? ☐Y ☐N If no, please explain: ___________________
____
Has you child had any chronic health problems? (Asthma, diabetes, heart condition, etc)
☐Y ☐N If yes, please explain: ____
____
Are immunizations up to date? ☐Y ☐N
Check which of the following illnesses this child has had:
☐ Mumps ☐ Chicken Pox ☐ Measles ☐ Whooping Cough ☐ Scarlet Fever
☐ Pneumonia ☐ Encephalitis ☐ Otitis Media (ear infections)
☐ Lead Poisoning ☐ Seizures ☐ Other
How many accidents has this child had? ☐1-3 ☐4-7 ☐8-12 ☐12+
Check if this child has had any accidents resulting in the following:
☐ Broken bones ☐ Head Injury ☐ Stomach Pumped ☐ Lost Teeth ☐ Severe Lacerations
☐ Severe Bruises ☐ Eye Injury ☐ Stitches ☐ Other
Check if this child has had surgery for any of the following conditions:
☐ Tonsillitis ☐ Appendicitis ☐ Leg or Arm ☐ Burns ☐ Adenoids ☐ Digestive Disorder
☐ Eye/Ear/Nose/Throat ☐ Hernia ☐ Urinary Tract ☐ Other
Does this child have bladder control problems?
At Night? ☐ Y ☐ N IF Yes, how often? ____
During the Day? ☐ Y ☐ N If yes, how often? ____
Does this child have bowel control problems?
At Night? ☐ Y ☐ N IF Yes, how often? ____
During the Day? ☐ Y ☐ N If yes, how often? ____
Has your child ever been diagnosed with a medical problem not already listed above? If so, please explain: ____
____
What are your child's current medical needs? ____
____

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Sexual Maturation History

At what age did your child show adult body development? ______________________________________

At what age did your daughter begin menstruating? ____

Were there any special problems with the onset of menstruation/body development? ☐ Y ☐ N

Does your child appear appropriately comfortable with the opposite sex? ☐ Y ☐ N

Have there been any pregnancies or abortions? ☐ Y ☐ N ☐ Don't know

Has your child ever been the recipient of or perpetrator of neglect, violence, or sexual abuse? ☐ Y ☐ N

If yes, please explain: ____
____
____

School History

Check any of the following school problems that apply

	Grade
☐ Oppositional	_____
☐ Disrupt Class	_____
☐ Inattentive	_____
☐ Refuse to go to school	_____
☐ Fail to turn in work regularly	_____
☐ Disorganized	_____
☐ Detention	_____
☐ In-school suspension	_____
☐ Out-of-school suspension	_____
☐ Expelled from school	_____

Has your child ever had problems with his or her learning ability? ☐ Y ☐ N

If yes, please explain: ____
____
____

Summarize your child's progress (eg. Grades, academics, social, behavioral) within each of the following grade levels. Also list whether public, private or home schooled.

Preschool: ____

Kindergarten: ____

Grades 1-3: ____

Grades 4-6: ____

Middle School/JR high: ____

High School: ____

Have instructional modifications been attempted? ☐ Y ☐ N

If yes, please explain: ____
____
____

Has this child had any educational testing? ☐ Y ☐ N

If yes, please explain: ____
____
____

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Social History

How does this child get along with his/her sibling(s)?

☐ Better than average ☐ Average ☐ Worse than average ☐ Doesn't have any

How easily does this child make friends?

☐ Better than average ☐ Average ☐ Worse than average

About how many close friends does your child have?

☐ None ☐ 1-2 ☐ 3-5 ☐ 5 or more

On the average, how long does your child keep friendships?

☐ Less than 6 months ☐ 6 months-1 year ☐ 2 years +

Describe your child socially: ☐ Withdrawn ☐ Insecure ☐ Outgoing ☐ Passive
☐ Aggressive ☐ Other

What extra-curricular activities is your child involved in? ____

____

____

What jobs or chores does your child have? ____

____

____

Has your child ever had any legal problems? ☐ Y ☐ N

If yes, please explain: ____

____

____

Are you aware of any alcohol, tobacco and/or other drug use by your child? ☐ Y ☐ N

If yes, please explain: ____

____

____

Religious/ Faith History

What is your family's religious background? ____

____

Does your child currently attend church/synagogue, or mosque? ☐ Y ☐ N

If yes, where: ____

Please list any issues (positive or negative) that are important and may have affected your child in regard to faith: ____

____

Family History

Check if there is any history of any of the following in the family. If yes, please list the family member (eg. Mother, grandfather, sibling)

Learning Disabilities ____________

ADD/ADHD _____________

Mental Retardation ____________

Depression ____________

Anxiety Disorder _____________

Tics or Tourettes _____________

Psychosis or Schizophrenia _____________

Alcohol or Drug Abuse ______________

Arrests ___________

Physical or Sexual Abuse ____________

Birth Defects _____________

Diabetes _____________

Suicide Attempts/Suicide ________________

Bipolar Disorder (Manic Depression) ______________

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Living Situation

Who has legal custody of your child? ____

☐ Both parent's home ☐ Relative's home
☐ One parent's home ☐ Friend's home
☐ Legal guardian's home ☐ Other

Primary living situation for the past year:

☐ Both parent's home ☐ Relative's home
☐ One parent's home ☐ Friend's home
☐ Legal guardian's home ☐ Other

Please describe the family home: ☐ House ☐ Apartment ☐ Condo

Please indicate who sleeps in each bedroom ____
____

Please describe your neighborhood ____
____

Who has taken care of the child most of their life? ____
____

Who is the primary disciplinarian in the family? ____

Are they: ☐ strict ☐ Lenient

Do parents agree on the issues of parenting, rules and discipline?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely

What strategies have been used to address problems? (Check those that apply and circle those that have been successful)

☐ Verbal Reprimands ☐ Time Out ☐ Removal of Privileges ☐ Rewards
☐ Physical Punishments ☐ Giving in to the Child ☐ Avoiding the Child

On the average, what percentage of the time does your child comply with initial commands?

☐ 0-20% ☐ 20-40% ☐ 60-80% ☐ 80-100%

On the average, what percentage of the time does your child eventually comply with commands?

☐ 0-20% ☐ 20-40% ☐ 60-80% ☐ 80-100%

Do parents get along with one another?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely

Have there been any major stressors or changes in the family where the child was raised?

☐ Y ☐ N If yes, check all that apply:

	In Past	Current (6 months or less)
Financial problems	_____	_____
Frequent Moves	_____	_____
Job Changes	_____	_____
Drinking/Drug Problems	_____	_____
Arguments between Parents	_____	_____
Separation or divorce of parents	_____	_____
Remarriage of Parent(s)	_____	_____
Separation from sibling(s)	_____	_____
Frequent Physical Punishment	_____	_____
Physical Confrontations btwn Parents	_____	_____
Mental Illness in Family	_____	_____
Physical Illness in Family	_____	_____

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Con't…	In Past	Current (6 months or less)
Psychiatric Hospitalization of Parent	_____	_____
Death in the Family	_____	_____
Incestuous Behavior in Family	_____	_____
Other ______________________	_____	_____

What are the family's strengths? ____
____
____

What are the family's weaknesses? ____
____
____

What are the child's strengths? ____
____
____

What are the child's weaknesses? ____
____
____

What do you see as an issue(s) important to the child: ____
____
____

Please mark any of the statements below that apply to your family:

	Yes	No
Our family is warm and loving	☐	☐
People are often arguing	☐	☐
Everyone goes his/her own separate way	☐	☐
People say what is on their minds	☐	☐
Our family hides things	☐	☐

What would you like to change about your family? : ____
____
____

How has the family been changed by the child's problems? : _____________________________________
____
____

What is the family's expectation of treatment? : ____
____
____

What does the family see as their role in treatment? Which family members are willing and able to participate? : ____
____
____

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Please list any disabilities or disorders that your child has that have not been previously mentioned:
____
____
____

Describe your child's adjustment to these disabilities and/or disorders: ___________________________
____
____

Is there a need for assistive technology in the treatment of this child? ☐ Y ☐ N
If yes, please state the need: ____
Is there anything else about this child or family that we should know in order to be more helpful? _____
____
____
____

*****Please bring this form, as well as psychological or educational test results, report cards, behavior modification charts and any other pertinent documents to your next appointment.***

_______________________________ ________________
Parent/Guardian Signature *Date*

Read and Reviewed by _______________________________ ________________
Clinician *Date*