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Child/Adolescent History Form

Child Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender_____

Race/Ethnicity: _____ Religious/Spiritual Affiliation (if applicable): _____

Parent/Guardian Relationship Status: _____

Other Important Cultural Information: _____

Presenting Problem:

Reasons for seeking services:

Please list current symptoms:

Mental Health History:

How long have these concerns been present regarding your child?:

Please list past outpatient therapy your child may have received:
(Name of therapist/length of time in therapy/type of work completed/past diagnoses)

Please list past inpatient mental health hospitalization your child may have received:
(Name of hospital/location/length of stay/age of hospitalization/reason for hospitalization)

Please list past and current medications your child has been prescribed/is using:
Medication name Dosage Reason for med. Taking as prescribed? (Y/N)

Educational History:

School Name: Grade: Primary Teacher Name: Please list/describe any trouble your child may be experiencing at school (academic or behavioral):

What are child's best and worst subjects?:

Has your child ever been diagnosed with a learning disorder?:

Does your child have an IEP/504 Plan in place?: (Y/N)
If Yes, please describe accommodations that have been recommended:

If Yes, are these accommodations, in your opinion, being implemented appropriately?

If No, do you think your child might need an IEP/504 Plan?: (Y/N)

Has your child ever received educational or psychological testing/evaluation in the past? (please describe):

Has your child ever been retained in a grade?: (Y/N) Please list reason for retention:

Has your child ever received special education services?: (Y/N) Please list reason for extra services:

Does your child enjoy school?:

Social Functioning:

Does your child make friends easily?

Does your child seem to have peers in whom your child can confide?: Please list activities in which your child is currently involved:

Medical History:

Please list any medical conditions your child has and rate how well managed they are (good, fair, poor):

Please list any surgeries your child may have had:

Please list any hospitalizations your child may have had for a medical condition/length of stay:

Developmental History:

If your child was adopted, please indicate age at adoption and any information you know about your child's life before the adoption:

Pregnancy history (please describe the pregnancy with the child including term of pregnancy, any pregnancy-related complications):

Birth process: Vaginal/Cesarean section?

Please note any complications that occurred during the birth process:
As an infant, was your child breast-fed, formula fed, or both? Please explain:
If you attempted to breast feed, please describe any challenges you experienced:

Please describe your child as an infant (cuddly, easy, difficult, colicky, active):

At what age did your child complete the following milestones?:

Smile at others:

Roll over from back to stomach:

Use a single word:

Crawl:

Form 2-3 word sentences:

Roll over from stomach to back:

Walk without holding on:

Remain dry during the day:

Remain dry at night:

Have you noticed regression on your child's part in any of those areas?

Did your child have any difficulty with sleeping as an infant/toddler?:

Did your child have any difficulty with eating as an infant/toddler?:

Discipline:

Please list what you have used historically and use presently for discipline with your child:

Are you experiencing any difficulty with consistently implementing effective discipline strategies?:

Family of Origin History:

Place of birth:

Who has cared for your child up to this point?:

Please list who currently lives in your household and the quality of those relationships:

Please list any current family stressors that are occurring:

Please list any family members who have diagnosed or suspected undiagnosed mental health conditions:

Trauma History:

Please circle/highlight any of the following your child may have experienced:

Physical abuse *Emotional/verbal abuse* *Natural Disasters*

Witnessing violence (including domestic violence) *Sexual abuse*

Confusing experiences/boundary violations *Bullying* *Peer Rejection*

Loss of a parent or other important caregiver

Substance Use:

Please check the following substances your child has used or may have used in the past as well as any substances you are aware your child is using currently:

Substance	Past	Current
Wine		
Liquor		
Beer		
Marijuana (any form)		
Cocaine		
Crack Cocaine		
Hallucinogens		
Inhalants		
“Club Drugs” (i.e. Ecstasy)		
Heroine		
Prescription Drugs (not as Prescribed)		
Stimulants		
Tobacco		
Caffeine		
Other		

Have you ever approached your child about your child’s substance use? Please describe the outcome:

Please list any prior treatment for drug or alcohol use: (Inpatient/Intensive Outpatient/Educational/Detox/Date/Location):

Legal History:

Charge Date of Arrest Juvenile Detention (Y/N) Probation (Y/N/Dates)

Strengths and Weaknesses:

Please list three of each to describe your child:

Strengths:

1.

2.

3.

Weaknesses:

1.

2.

3.

Other Important Information About Your Child That Dr. Kasper Should Know:

Goals for therapy (if applicable):

Short Term

1.

2.

3.

Long Term

1.

2.

3.