



Woodview Psychology Group, LLC

70 E. 91st Street, Suite 210
Indianapolis, IN 46240
www.woodviewgroup.com

Telephone: 317-573-0149
Fax: 317-573-0154

Child/Adolescent Background

Child's Name: _____ Preferred name: _____

Today's Date: _____ Person completing form: _____

What are your primary concerns regarding your child/specific questions you would like help with?

When did you first become concerned about your child?

Early Developmental History:

Is this child your biological child or adopted? (circle) *biological* *adopted*

If adopted, at what age did you adopt this child? _____

If adopted, please list country of birth for this child: _____

Did the pregnancy have any complications? No Yes: (explain) _____

How long was the pregnancy? _____ Baby's birth weight: _____

Were there any difficulties caring for this child during the first year? No Yes: _____

Did you seek any services, such as First Steps, in the first 3 years? No Yes: _____

Please list the age your child reached the following milestones:

said first word: _____ used simple sentences: _____

sat up alone: _____ crawled: _____ walked alone: _____

toilet trained during day: _____ dry at night: _____

Medical History:

Please list current medications, including over-the-counter:

Name of medication	Dose/frequency	Length of time on medication	Name of Prescribing Physician

Please circle yes/no for a history of any of the following, and explain if yes:

- Allergies No Yes: _____
- Hearing problem No Yes: _____
- Vision problem No Yes: _____
- Hospitalization No Yes: _____
- Serious accident No Yes: _____
- Serious illness No Yes: _____
- Chronic illness No Yes: _____
- Seizure No Yes: _____
- Tics No Yes: _____
- Night terrors No Yes: _____

Please circle yes/no for the following current concerns, and explain if yes:

- Eating problems No Yes: _____
- Sleep problems No Yes: _____
- Bedwetting No Yes: _____
- Stomachaches No Yes: _____
- Headaches No Yes: _____
- Menstrual cycle No Yes: _____

Please circle yes/no for any of these services that your child is receiving, or did receive in the past:

- Speech/language therapy No Yes: _____
- Occupational therapy No Yes: _____
- Physical therapy No Yes: _____
- Counseling No Yes: _____
- Educational tutoring No Yes: _____

Educational History:

Name of current school: _____ Grade: _____

Circle if your child has any of the following: *GEI 504 ICEP IEP*

If your child has an IEP, circle the classification: *LD ASD CD OHI ED Mi/MoMD*

If your child has an IEP, what services are provided: _____

What grades, or GPA, does your child currently have? _____

Circle your child's most recent ISTEP: English: *passed failed* Math: *passed failed*

Did your child ever repeat a grade? No Yes (what grade): _____

Please list all schools your child attended; list for what grades if s/he attended more than one school. If you homeschooled your child for any of these years, please note this as well:

Preschool: _____

Elementary: _____

Middle school: _____

Intermediate/Junior High: _____

High School: _____

Has your child had any testing through the school? No Yes (when): _____

Have you sought testing for educational concerns anywhere? No Yes (when): _____

Is homework completion an area of concern? No Yes (explain): _____

Has the school contacted you about behavior concerns? No Yes (explain): _____

Social History:

List all extracurricular activities (sports, clubs, etc) that your child has been involved with over the last 6 months: _____

List the activities/toys your child enjoys in free time: _____

Does your child entertain him/herself well? No Yes (explain): _____

Do you have any concerns about your child's social development? No Yes (explain): _____

How is your child getting along with siblings and parents? _____

How is your child getting along with other children his/her age? _____

What do you think of your child's closest friends/peer group? _____

Do you have any concerns about alcohol/drug use? No Yes (explain): _____

Have there been any legal problems? No Yes (explain): _____

Are you concerned about sexual activity? No Yes (explain): _____

Family Information:

Please list who has legal guardianship of this child: _____

Please circle parents' marital status: *Never married Married Separated Divorced Widowed*

If parents are separated, divorced, or widowed, please explain when this occurred: _____

If parents are separated or divorced, please describe the custody arrangements: _____

If one of the parents is NOT living in the child's primary home, please explain the frequency of contact: _____

Please list all persons living in the child's primary home:

Name of person	Relationship to child	Age	Gender (M/F)	Highest grade/degree

If any immediate family member (e.g., parent, sibling) is living elsewhere, please list:

Name of person	Relationship to child	Age	Gender (M/F)	Highest grade/degree

Please circle yes/no for any of the following in the last year, and explain if yes:

- | | | |
|-----------------------------------|----|------------|
| Family move | No | Yes: _____ |
| Marital problems | No | Yes: _____ |
| Serious parent illness | No | Yes: _____ |
| Serious sibling illness | No | Yes: _____ |
| Serious accident to family member | No | Yes: _____ |
| Parent job difficulties | No | Yes: _____ |
| Death of close family member | No | Yes: _____ |

Please circle yes/no for a family history of the following. If yes, list who had these issues:

- | | | |
|-----------------------|----|------------------|
| Learning difficulties | No | Yes (who): _____ |
| ADHD/ADD | No | Yes (who): _____ |
| Anxiety problems | No | Yes (who): _____ |
| Autism | No | Yes (who): _____ |
| Depression | No | Yes (who): _____ |
| Bipolar disorder | No | Yes (who): _____ |
| Suicide attempt | No | Yes (who): _____ |
| Drug/alcohol problem | No | Yes (who): _____ |
| “Nervous breakdown” | No | Yes (who): _____ |
| Schizophrenia | No | Yes (who): _____ |
| Any genetic syndrome | No | Yes (who): _____ |
| Seizure disorder | No | Yes (who): _____ |
| Thyroid problems | No | Yes (who): _____ |
| Type I Diabetes | No | Yes (who): _____ |

If there is other information that you think will be helpful to us, please explain below:
