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## 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: | Sat up alone: | Toilet trained: |
| Used simple sentences: | Crawled: | Dry at night: |
| | Walked alone: | |

**Medical History:**

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

| Name of medication | Dose/frequency | Length of time on medication | Name of Prescribing Physician |
|---|---|---|---|
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Please check no or yes 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 check no or yes for the following <u>current</u> 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 check no or yes for any of these services that your child is receiving, or did receive in the past:

Speech/lang. 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:

Has your child has any of the following: ☐*GEI* ☐*504* ☐*ICEP* ☐*IEP*

If your child has an IEP, select 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?

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:

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, 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 |
|---|---|---|---|---|
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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: