

COMPREHENSIVE CHILD AND ADOLESCENT HISTORY FORM

THIRD EDITION

Developed by:
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Child's Name: _____ Date of Birth: _____

Ethnicity/Cultural Identification: _____ Gender: _____ Age: _____

Person Completing the Form: _____ Relationship to Child: _____

General Instructions

Dear Parents/Guardians:

As part of our work with this child or adolescent, we ask that you fill out this form as fully and openly as possible. This information is helpful to ensure an accurate assessment, which will assist us in making appropriate recommendations. You may add or attach any additional information that you feel would be helpful in the evaluation process (e.g., past evaluation reports, report cards, etc.). We appreciate your cooperation and willingness to complete this form and to return it promptly to our office. When completing the forms, consider the following instructions:

1. Read the questions carefully and answer them in full.
2. Write as legibly as possible.
3. The child's parent/guardian should complete all forms. If parents/guardians wish to complete two separate packets, contact our office for an additional set of forms.
4. Please understand this information is for evaluation, intervention, and recommendation purposes. The information you provide *will* be part of the evaluation. If there are specific details that you are hesitant in sharing, contact our office for clarification or a private meeting.

Thank you in advance for completing this form.



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REFERRAL INFORMATION

Describe your concerns regarding this child (include details and dates when problems began).

Describe what you see as the cause of these difficulties.

Describe services or interventions you would like to see for this child.

Describe this child’s strengths.

FAMILY INFORMATION

List the names and information requested for all individuals living in the household (include caregivers, siblings, stepparents, etc.).

<i>Name</i>	<i>Age</i>	<i>Relationship</i>	<i>Comments/Concerns</i>

Father/Guardian: _____ Age: _____ Education: _____
 Occupation: _____ Employer: _____

Mother/Guardian: _____ Age: _____ Education: _____
 Occupation: _____ Employer: _____

Parents are: Married Separated Divorced Never married

Is this child living with both biological parents? Yes No

If no, explain: _____

If parents are separated or divorced, indicate the date and describe the present custody and visitation arrangements.

Are there any siblings living outside the home? Yes No

If yes, list names, ages, and any concerns: _____

What is the primary language spoken at home? _____

Does the family speak a second language? Yes No Language: _____

If yes, circle child's proficiency: Fluent Limited Other

Check if there is a family history of any of the conditions or problems noted below.

<i>Condition/Concern</i>	<i>Mother</i>	<i>Father</i>	<i>Siblings</i>	<i>Other Relatives</i>
Learning or School-Related Problems				
Developmental Disability (e.g., MR, ASD)				
Attention Problems				
Behavior Problems				
Emotional Problems/Mental Health				
Substance Abuse/Addiction				
Medical Problems				

Provide explanation of any items checked above: _____

List any agencies/caseworkers currently involved with this child or family (i.e., CYS, MH/MR, etc.).

Describe any major stresses that have occurred in the family that may be affecting this child (e.g., death of family member, divorce, etc.).

DEVELOPMENTAL HISTORY

Did this child’s mother receive prenatal care? Yes No

Was the pregnancy with this child normal? Yes No

Check any of the following health complications that occurred during the pregnancy.

- | | | |
|--|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Vaginal bleeding | <input type="checkbox"/> Toxemia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Trauma/injury |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Abnormal weight gain |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive swelling | <input type="checkbox"/> Excessive vomiting |
| <input type="checkbox"/> Blood incompatibility | <input type="checkbox"/> Preeclampsia | <input type="checkbox"/> Other: |

Provide explanation of any items checked above: _____

Check any of the following used by the mother during the pregnancy.

- Prescription medication: *(list name and dose)* _____
- Over-the-counter medications: *(list name and dose)* _____
- Illegal substances: *(list name and amount)* _____
- Alcoholic beverages: *(list type and amount)* _____
- Cigarettes: *Number of cigarettes per day:* _____

Provide further information regarding pregnancy, as needed.

What was the length of pregnancy? _____ weeks

Was the labor and delivery normal? Yes No

If no, explain: _____

The delivery was: Vaginal Cesarean (reason): _____

Check any of the following complications that occurred during the delivery.

- | | | |
|---|---|---|
| <input type="checkbox"/> Breech birth | <input type="checkbox"/> Cord around neck | <input type="checkbox"/> Meconium staining |
| <input type="checkbox"/> Lack of oxygen (turned blue) | <input type="checkbox"/> Forceps used | <input type="checkbox"/> Suction used |
| <input type="checkbox"/> Labor induced | <input type="checkbox"/> Medication for labor | <input type="checkbox"/> Cardiopulmonary distress |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Provide explanation of any items checked above: _____

Did the baby breathe spontaneously? Yes No

What was this child's birth weight? _____ Pounds _____ Ounces

How long was the baby's hospital stay? _____ days

How long was the mother's hospital stay? _____ days

Describe child's general behavior, eating, and sleeping as an infant and toddler.

Indicate the age in which this child achieved the following milestones (*estimate if unsure*).

Sat alone: _____ Spoke first word: _____

Crawled: _____ Put 2-3 words together: _____

Stood alone: _____ Spoke in sentences: _____

Walked alone: _____ Learned alphabet: _____

Toilet trained: _____ Began to read: _____

Dry through Night: _____ Tied Shoes: _____

Indicate any of the following developmental concerns.

- Poor motor skills (describe): _____
- Oral motor problems (e.g., drooling, etc.) (describe): _____
- Speech delay/problems (describe): _____
- Problems with bedwetting (until what age?): _____
- Problems with daytime urine accidents (until what age?): _____
- Problems with soiling accidents (until what age?): _____

Did this child receive Early Intervention or Specialized Preschool Programming? Yes No

If yes, explain: _____

MEDICAL AND MENTAL HEALTH INFORMATION

How is this child’s overall health? Poor Fair Good Excellent

List any serious illnesses, accidents, injuries, hospitalizations, or surgeries.

<i>Incident</i>	<i>Date(s)</i>	<i>Provide Details</i>

Has this child’s vision been checked? Yes No Any problems? _____

Has this child’s hearing been checked? Yes No Any problems? _____

Date of last physical examination: _____ By Whom: _____

Check any current or past concerns, provide a brief description.

<i>Condition</i>	<i>Occurrence</i>			<i>Provide Details for Each Checked</i>
Allergies	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Asthma	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Diabetes	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Seizures/Convulsions	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Failure to thrive	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	

Loss of consciousness	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
High fevers	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Motor or vocal tics	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Lead poisoning	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Dizziness/blurred vision	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Stomach pain	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Urination problems	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Constipation	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Frequent ear infections	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Ear tubes placed	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Staring spells	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Sleep problems	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Frequent headaches	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Meningitis	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Encephalitis	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Epilepsy	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Exposure to toxin	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Head banging	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Temper tantrums	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Excessive vomiting	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Eating problems	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Self-injurious behavior	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Repetitive movements	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Impulsivity	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Clumsiness/Accident prone	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Rocks back and forth	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Under-eating	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Overeating	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Eating nonfood items	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Other: _____	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	
Other: _____	<input type="checkbox"/> Past	<input type="checkbox"/> Current	<input type="checkbox"/> Never	

Describe any head injuries (e.g., loss of consciousness, stroke, skull fractures, etc.), including dates, treating providers, and outcomes.

List any medications this child takes on a regular basis.

<i>Medication</i>	<i>Dosage/ Frequency</i>	<i>Purpose</i>	<i>Side Effects</i>

Check all of the following evaluations that have occurred in the part and provide requested details.

<i>Previous Evaluations</i>	<i>Date(s)</i>	<i>Provider</i>	<i>Reason and Outcome/Diagnosis</i>
<input type="checkbox"/> Psychological			
<input type="checkbox"/> Psychiatric			
<input type="checkbox"/> Speech/Language			
<input type="checkbox"/> Neurological			
<input type="checkbox"/> Other: _____			

Has this child ever experienced or been witness to any traumatic events? Yes No

If yes, explain: _____

List any mental health/behavioral treatment received (e.g., inpatient, outpatient, substance, etc.).

<i>Dates of Service</i>	<i>Provider</i>	<i>Reason</i>	<i>Outcome</i>

Provide any additional information regarding this child’s medical or mental health background.

EDUCATIONAL INFORMATION

List all schools this child has attended (include preschool).

<i>School</i>	<i>Location</i>	<i>Grade(s)</i>	<i>Comments/Problems</i>

Has this child ever repeated or skipped a grade? Yes No

If yes, indicate which grade(s) and reasons:

Has this child ever been tested for special services in school? Yes No

If yes, indicate the results:

Has this child ever received special services in school? Yes No

If yes, describe:

Describe this child's academic and/or behavioral strengths in school.

Describe this child's academic and/or behavioral weaknesses or needs in school.

What has the school told you about this child's performance in school?

Has the school listened to your concerns regarding this child? Yes No

If no, explain what you would have liked to be different? _____

Has this child missed many days of school over the past two years? Yes No

If yes, explain: _____

Does this child like to go to school? Yes No

If no, explain: _____

Does this child have complaints about school? Yes No

If yes, explain: _____

Provide any additional information regarding this child's educational or school background.

SOCIAL INTERACTIONS

- Does this child have difficulty relating to or playing with other children? Yes No
- Does this child interact better with adults than children his or her own age? Yes No
- Does this child have difficulty making and keeping friends? Yes No
- Does this child have difficulty understanding social cues? Yes No
- Does this child have difficulty with peer pressure? Yes No

If you checked yes for any of the above questions, describe your response.

ADDITIONAL INFORMATION

Provide information on this child's interests.

List any activities this child dislikes.

What types of discipline are used with this child at home (indicate effectiveness)?

Has this child been arrested or involved in any legal issues (e.g., probation, etc.)? Yes No

If yes, explain:
