Complete Child/Adolescent History Packet rev.08.2020

1. Child's Name: Date of Birth:

Person Completing Form:

Child's Age: Gender:
○ Male ○ Female
○ Other

Primary Mailing Address:

Primary Contact Phone Number:

Parent or Legal Guardian's Name:

Does parent/legal guardian named above have legal authority to consent to mental health treatment?

2. **Upload proof of guardianship and/or custody agreement paperwork here or email admin@hmpsychology.com**

I understand that in cases of separation, divorce, or foster care placement, I am responsible for providing proof of guardianship and/or custody agreement to Healthy Minds Psychology Assoc. PRIOR TO my child's initial appointment or the appointment will be RESCHEDULED.

Signature

3. **Parents, please upload your driver's license or photo identification AND insurance card (if applicable).**

4. Parent 1: ☐ Mother ☐ Father

Phone Number: Email:

Occupation: Work Number:

Parent 2: ☐ Mother ☐ Father

Phone Number: Email:

Occupation: Work Number:

Do we have permission to leave messages on primary contact phone number? Please indicate any restrictions.

School Name: System: Grade:

5. REASON FOR REFERRAL

Who referred you to our office?

Do we have your permission to thank this person for the referral?
○ Yes ○ No

6. Please briefly describe your child's presenting concern(s):

7. Which of these concerns are also reported by the child's teacher:

How long have these problems been noticeable to you?

8. What strategies have been tried to address problems?

☐ Counseling ☐ Medication ☐ School Intervention
☐ Home Discipline ☐ Nothing so far ☐ Other

If other, please specify:

9. How have strategies worked?

10. What are your current goals for psychological testing or therapy?

11. Symptom Checklist- Internalizing Problems

- ☐ Often anxious/tense
- ☐ Worries a lot
- ☐ Sudden mood changes
- ☐ Dislikes affection/physical contact
- ☐ Cries easily and often
- ☐ Has trouble relaxing
- ☐ Suicidal thoughts/attempt
- ☐ Parent relationship problems
- ☐ Poor eye contact
- ☐ Sensory (sensitive to tags, loud noises, avoids hugs)
- ☐ Seems uneasy or awkward interacting with peers
- ☐ Repetitive movements (e.g., hand flapping)
- ☐ Lacks effort
- ☐ Appetite: eats too much or too little
- ☐ Has obsessive interests
- ☐ Nightmares
- ☐ I HAVE NO CONCERNS
- ☐ Sadness/depressed
- ☐ Overreacts to small mistakes
- ☐ Refuses to sleep alone
- ☐ Complains of sickness
- ☐ Too clingy/dependent
- ☐ Hearing Voices/Seeing Things- Hallucinations
- ☐ Talks about death
- ☐ Tired/low energy
- ☐ Poor social skills
- ☐ Acts as if he/she cannot hear
- ☐ Repeats things over and over
- ☐ Difficulty making friends
- ☐ Has low motivation
- ☐ Difficulty getting to sleep
- ☐ Has few friends
- ☐ Poor hygiene
- ☐ Has strong fears
- ☐ Panic attacks
- ☐ Withdrawn or spends too much time alone
- ☐ Emotionally detached
- ☐ Low self-esteem
- ☐ Self-harm behaviors (bites, scratches, hits self)
- ☐ Talks of harming others
- ☐ Bed wetting
- ☐ Language delays
- ☐ Obsessive thoughts/strong fixations
- ☐ Extremely upset with changes in routine
- ☐ Complains of health problems
- ☐ Grades have declined
- ☐ Sleeps too much
- ☐ Cranky and irritable
- ☐ Eats non-food items

Provide examples or additional information for items selected above.

_____

12. Clinician Notes:

_____

_____

_____

_____

13. Symptom Checklist- Externalizing Problems

- ☐ Anger/ Irritability
- ☐ Argumentative with adults
- ☐ Uses profanity
- ☐ Breaks things when angry
- ☐ Difficulty focusing
- ☐ Difficulty completing tasks
- ☐ Cannot sit still
- ☐ Easily bored
- ☐ Constantly loses things
- ☐ Has poor writing skills
- ☐ Suspended from school
- ☐ Property Destruction, vandalism
- ☐ Easily annoyed
- ☐ Runs away from home
- ☐ Steals outside of home
- ☐ Uses alcohol or drugs
- ☐ Oppositional, Defiant
- ☐ In conflict with family
- ☐ Gets into fights
- ☐ Manipulates others
- ☐ Easily distracted
- ☐ Short attention span
- ☐ Acts impulsively
- ☐ Does not understand directions
- ☐ Has difficulty with reading
- ☐ Plays with or starts fires
- ☐ Physically hurts others
- ☐ Legal Problems/ arrests
- ☐ Hangs with peers who get into trouble
- ☐ Cruel to animals
- ☐ Lying
- ☐ Has boundary issues (invades personal space)
- ☐ Does not get along with peers
- ☐ Temper tantrums
- ☐ Has a bad temper
- ☐ Memory problems
- ☐ Often makes careless mistakes
- ☐ Talks ExcessivelyFidgets/ Restless
- ☐ Earns poor grades
- ☐ Forgets things easily
- ☐ Has difficulty with math
- ☐ Skips school
- ☐ Behavior problems in school
- ☐ Lacks remorse
- ☐ Lacks respect for authority
- ☐ Steals from home
- ☐ Sexual Acting Out or Promiscuity
- ☐ I HAVE NO CONCERNS

Provide examples or additional information for items selected above.

_____

14. Clinician Notes:

_____

_____

_____

_____

Family History

15. Marital status of parents:

- ○ Single
- ○ Separated
- ○ Widowed
- ○ Married
- ○ Divorced
- ○ Single- Living Together

Which parent does the child currently live with?

_____

16. If parents are separated or divorced:

How old was child when separation occurred? How often does the child see the other parent?

Have one or both parents remarried? Which parent?

Please describe your child's relationship with stepparent/ stepsiblings.

Describe child's adjustment to the separation/ divorced and how do you think this impacted him or her?

17. How many siblings does your child have (List their gender and ages)?

18. List all people living in the household (other than child):

	Name	Relationship to Child	Age	Describe child's relationship with this person
1				
2				
3				

Other:

19. How would you rate the current level of stress within the home environment?

- ○ Low
- ○ Average
- ○ High

20. Please explain.

21. Has the child experienced any recent or previous trauma, abuse, or major stressful life events?

☐ Yes ☐ No

_____ _____

22. Please check if your child has experienced any of the following types of trauma or loss:

- ☐ Emotional abuse
- ☐ Lived in a foster home
- ☐ Crime victim (robbery)
- ☐ Sexual assault
- ☐ Parental Divorce
- ☐ Homelessness
- ☐ Parent physical or mental illness
- ☐ Financial problems
- ☐ Severe bullying
- ☐ None
- ☐ Physical abuse/ Neglect
- ☐ Exposure to violence in the home
- ☐ Parent substance abuse
- ☐ Parental Incarceration
- ☐ Sexual abuse
- ☐ Multiple family moves
- ☐ Loss of a loved one
- ☐ Traumatic accident (car, natural disaster)
- ☐ Legal issues

23. Please provide history of mental health problems within the birth family:

Condition/ Symptom	Yes	Relation to Child
Cognitive Delays		
Anxiety		
ADHD		
Bipolar Disorder/ Manic Depression		
Depression		
Schizophrenia		
Psychotic Disorder		
Autism Spectrum Disorder		
Learning Disability (Dyslexia, Math problems, special education)		
Seizures/Neurological Dx		
Phobias/ Panic Attacks		
Psychiatric Hospitalization		
Post-traumatic Stress		
Suicide attempt/Completion		
Alcohol/ Drug Problem		
Anger/ Rage		
None		

Describe any undiagnosed family mental health issues.

Birth History

24. Birth/ Delivery

Was child adopted?
○ Yes ○ No

Age at adoption:

If yes, complete maternal history as best as possible:

Mother's age at child's birth:

Father's age at child's birth:

25. During the pregnancy, check if the mother experienced any of the following complications:

- ☐ Suffered From Illness or Disease
- ☐ Toxemia
- ☐ High Blood Pressure
- ☐ Maternal Anemia
- ☐ Alcohol Use
- ☐ Smoked Tobacco
- ☐ Excessive Blood Loss
- ☐ Loss of Consciousness
- ☐ Bed Rest
- ☐ Took Medication
- ☐ Surgery
- ☐ Drug Use
- ☐ Nutrition/Weight Problems
- ☐ Excessive Vomiting
- ☐ Diabetes
- ☐ Infection(s)
- ☐ Threatened Miscarriage
- ☐ None

If other, please specify:

_____

26. If Surgery, please provide details:

_____

27. Delivery and Post-Delivery

Child was born:
○ Premature ○ On time ○ Late
○ Unknown or N/A

Birth Weight: (lbs.) _____

Birth Weight: (ozs.) _____

28. Type of Delivery:

- ○ Normal
- ○ Caesarean
- ○ Breech
- ○ Multiple Birth

29. Neonatal Complications:

- ☐ None
- ☐ Breathing problems
- ☐ Infection
- ☐ Genetic problems
- ☐ Anemia
- ☐ Jaundice
- ☐ Addiction
- ☐ Other
- ☐ Birth defects
- ☐ Feeding problems
- ☐ Cyanosis (turned blue)

If other, please specify:

_____

30. Temperament as an infant:

- ☐ Easy-going
- ☐ Difficult to Soothe
- ☐ Irritable
- ☐ Other
- ☐ Passive

If other, please specify:

_____

31. Activity Level:

Stage	Less than Average	Average	Overly Active
Infant:			
Toddler:			
School-age:			

Developmental History

32. The following is a list of developmental behaviors. For each behavior you can remember, please indicate the age at which your child first demonstrated the skill. If you are not certain of the exact age, check whether it was early, normal, or late.

Skill	Early	Normal	Late	Age Developed
Sat without support				
Crawled				
Stood without support				
Walked without assistance				
Spoke first words				
Spoke in phrases				
Spoke in sentences				
Used spoon without help				
Used scissors to cut pictures				
Buttoned Clothing				
Toilet trained				
Named Colors				
Said alphabet in order				
Tied shoelaces				
Began to read				
Rode bicycle without training wheels				

33. Has your child had any early intervention, such as speech therapy or occupational therapy? If so, list dates of service and frequency.

Medical History

34. Please explain any significant medical problems, diagnoses or illnesses your child has had (e.g., ear infections, asthma, seizures, diabetes, etc):

Does child have allergies? List them:

Explain any previous head injuries or accidents:

Previous medical hospitalizations (Approximate dates and reasons):

35. Name of Child's Primary Care Physician:

List other doctors involved in his/her care & Specialty:

Does your child have vision problems?

Does he/she wear:
☐ Glasses ☐ Contacts
☐ Has glasses/contacts but does not wear them

Does your child have hearing problems or history of hearing problems? If so, describe.

Please describe any past or current problems in your child's appetite, including any weight loss or gain:

Which of the following describes your child's diet:
☐ Eats organically/vegetarian/vegan ☐ Eats Junk Foods ☐ Eats well balanced meals ☐ Gluten Free
☐ He/she overeats or binge-eats ☐ Eating habits need improvement ☐ He/she restricts diet ☐ Other

36. Please describe any past or current problems with your child's sleeping:

Any snoring or breathing problems while sleep?

How many hours of sleep does he/she get at night?

Child's current height:

Child's current weight:

37. Rate your child's health:

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor
- ○ Declining

Psychological Treatment History

38. Has your child been previously diagnosed with a psychological disorder (e.g., ADHD, depression)?

	Diagnosis	Date/age at diagnosis	Diagnosed by	Current functioning w/ diagnosis
1				
2				
3				

39. Previous psychiatric hospitalizations (Approximate dates and reasons):

Describe any previous suicide threats, ideation, or attempts.

Has your child ever had any previous mental health treatment (e.g., medication from psychiatrist, counseling, or executive functioning)? If yes, please list approximate dates and reasons.

Has your child had a previous evaluation -psychological, psychiatric, school, or neurological? (Approximate dates and reasons for evaluation):

40. List any current medications your child is taking (include over the counter drugs, vitamins, supplements):

	Medication Name	Condition Requiring	Date started	How well is medication working
1				
2				
3				

41. List any prescription medications your child has taken in the past:

	Medication Name	Condition Requiring:	Years on medication	Reason for stopping medication
1				
2				
3				

Social Relationships

42. How satisfied do you think your child is with his/her current friendships, school performance, and home life?

Describe any difficulty your child has getting along with peers his/her same age or teachers.

Describe any difficulty your child has developing and maintaining friendships.

Does your child exhibit any unusual habits or behaviors (e.g., hand flapping, strong attachment to objects). Explain.

Strengths & Self-care

43. What are your child's strengths?

How would you describe your child's ability to care for him/her self and cope with challenges?

List child's extra-curricular activities including sports, clubs, hobbies, and lessons.

Educational History

44. Describe primary concerns at school (e.g., academic, behavioral, grades, social).

Did child have difficulty developing reading, writing, spelling, or math skills? Explain.

Has your child repeated a grade in school? If so, which?

Has your child failed to pass GA Milestones or other standardized tests? If so, explain (test, grade, subject area).

Has child ever been suspended or expelled from any school or sent to an alternative school? If so, explain.

45. **Please summarize your child's progress within each of these grade levels. Provide specific examples when possible.**

Grade Level	Name of School	List Academic Problems. What were his/her grades?	Describe Social/ Emotional Problems?	Describe Behavioral Issues?
Daycare/Preschool				
Kindergarten				
1st				
2nd				
3rd				
4th				
5th				
6th				
7th				
8th				
9th				
10th				
11th				
12th				

46. **Please describe any support services your child has received or is currently receiving (check all that apply).**

☐ Has special education/ IEP

☐ Student Support Team (SST)/RTI

☐ Early Intervention (EIP)/ Tutoring

☐ Has 504 Plan

☐ No history of support services

☐ Other:

47. **If special education/ IEP, under which eligibility category?**

For: Grade/Age Started:

48. **If received Early Intervention (EIP), which academic area was supported:**

49. **If tutoring, which academic area has been supported by tutoring:**

50. **If 504 Plan, Please list all his/her accommodations, even if accommodations are informal:**

51. Do you have any concerns about the quality of your child's school, instruction, or teachers?

Is there anything else important that you would like me to know about your child?

52. **This section to be completed by assigned clinician**

Plan:

☐ Psychological Testing ☐ Therapy ☐ Therapy for _____ sessions, then consider psychological testing

☐ Referral ☐ Executive Functioning

If Psychological Testing, Rule Out: Evaluation Type:

Therapy Referral: Referral(s):

Clinician Notes: