



## CHILD/ADOLESCENT INFORMATION

Minor's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
ID/SS# \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Stepfather's Name \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_ Stepmother's Name \_\_\_\_\_

## PARENTAL BACKGROUND

Father's Occupation \_\_\_\_\_  
Academic difficulties of father (*describe*) \_\_\_\_\_  
Medical difficulties of father (*describe*) \_\_\_\_\_  
Mother's occupation \_\_\_\_\_  
Academic difficulties of mother (*describe*) \_\_\_\_\_  
Medical difficulties of mother (*describe*) \_\_\_\_\_  
Is there a family history of mental health problems?  N  Y (*describe*) \_\_\_\_\_  
\_\_\_\_\_  
Are the minor's parents living together?  Y  N (*how old was the minor when they separated*) \_\_\_\_\_  
If parents are separated/divorced, what is the custody agreement? \_\_\_\_\_  
\_\_\_\_\_  
Sibling's Names & Ages \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Primary language spoken in the home \_\_\_\_\_ Other languages spoken in the home \_\_\_\_\_

## EDUCATION/LEARNING

How well does the minor do in school (avg grade or GPA) \_\_\_\_\_  
Does the minor have difficulty with any school subjects?  N  Y (*specify*) \_\_\_\_\_  
Has the minor had any special tutoring or counseling?  N  Y (*specify*) \_\_\_\_\_  
Has the minor ever failed (repeated) any grades?  N  Y (*specify*) \_\_\_\_\_  
Has anyone told you that the minor has a learning disability?  N  Y (*specify*) \_\_\_\_\_  
Has anyone told you that the minor is hyperactive or has ADD/ADHD?  N  Y  
Was the minor ever placed in special classes in school?  N  Y (*specify*) \_\_\_\_\_

## PRENATAL HISTORY

Did the minor's mother:

Take any medication during pregnancy?  N  Y (specify) \_\_\_\_\_

Smoke during pregnancy?  N  Y (how many cigarettes per day) \_\_\_\_\_

Drink alcohol during pregnancy?  N  Y (specify kind and amount) \_\_\_\_\_

Use illicit drugs during pregnancy?  N  Y (specify kind and amount) \_\_\_\_\_

Have prenatal care?  N  Y      Feel emotionally unprepared/unwanted pregnancy?  N  Y

## BIRTH HISTORY

Were there any problems during the pregnancy, labor, or delivery?  N  Y (specify) \_\_\_\_\_

Was the birth premature?  N  Y (how many weeks?) \_\_\_\_\_

Were there any birth defects or complications after delivery?  N  Y (specify) \_\_\_\_\_

## STRESSORS

Please check any of the following events that have occurred in your family or to your child:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Loss of job by parent      | <input type="checkbox"/> Mother beginning to work      | <input type="checkbox"/> Discovery of being adopted         |
| <input type="checkbox"/> Death of a parent          | <input type="checkbox"/> Child changes school          | <input type="checkbox"/> Addition of new adult to family    |
| <input type="checkbox"/> Marital separation/divorce | <input type="checkbox"/> Child is a victim of violence | <input type="checkbox"/> Witnessed violence                 |
| <input type="checkbox"/> Natural disaster           | <input type="checkbox"/> Physical abuse                | <input type="checkbox"/> Child acquires a visible deformity |
| <input type="checkbox"/> Sexual abuse               | <input type="checkbox"/> Emotional abuse               | <input type="checkbox"/> Family member in trouble with law  |
| <input type="checkbox"/> Physical neglect           | <input type="checkbox"/> Emotional neglect             | <input type="checkbox"/> Death of close family member       |
| <input type="checkbox"/> Birth of a sibling         | <input type="checkbox"/> Other (specify) _____         |   |

## INFANT DEVELOPMENT

At what age (year, months) did the minor begin to:

Sit alone \_\_\_\_\_ Crawl \_\_\_\_\_ Stand alone \_\_\_\_\_ Walk alone \_\_\_\_\_

Speak first word \_\_\_\_\_ Speak First sentence \_\_\_\_\_ Become toilet trained \_\_\_\_\_

## MEDICAL HISTORY

Please check any of the following that minor has experienced:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Ear-ache/infection    |
| <input type="checkbox"/> Prolonged fever          | <input type="checkbox"/> Head injury          | <input type="checkbox"/> Seizures/convulsions  |
| <input type="checkbox"/> Extended hospitalization | <input type="checkbox"/> Operations/surgeries | <input type="checkbox"/> Vomiting spells       |
| <input type="checkbox"/> Sustained medications    | <input type="checkbox"/> Physical handicaps   | <input type="checkbox"/> Wetting/soiling pants |
| <input type="checkbox"/> Other                    |   |  |

Please explain anything checked above \_\_\_\_\_

## SOCIAL DEVELOPMENT

Please check any of the items below that you feel describe the minor's behavior:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Difficulty making friends | <input type="checkbox"/> Hugs/cuddles       | <input type="checkbox"/> Acts shy           |
| <input type="checkbox"/> Prefers to be alone       | <input type="checkbox"/> Teases others      | <input type="checkbox"/> Is a good sport    |
| <input type="checkbox"/> Fights with others        | <input type="checkbox"/> Cooperates         | <input type="checkbox"/> Shares toys, etc   |
| <input type="checkbox"/> Prefers adults to kids    | <input type="checkbox"/> Easily embarrassed | <input type="checkbox"/> Avoids eye contact |
| <input type="checkbox"/> Seems withdrawn           | <input type="checkbox"/> Puts self down     | <input type="checkbox"/> Overly sensitive   |
| <input type="checkbox"/> Other (specify) _____     |   |   |

## EMOTIONAL DEVELOPMENT

Please check any of the items below that you feel describe the minor's behavior:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Poor self-esteem      | <input type="checkbox"/> Nail biting                     | <input type="checkbox"/> Sucks thumb          |
| <input type="checkbox"/> Nervous blinking      | <input type="checkbox"/> Frequent crying                 | <input type="checkbox"/> Tantrums             |
| <input type="checkbox"/> Mood changes          | <input type="checkbox"/> Difficulty controlling emotions | <input type="checkbox"/> Feelings easily hurt |
| <input type="checkbox"/> Excessive worrying    | <input type="checkbox"/> Can't express feelings          | <input type="checkbox"/> Unhappy or depressed |
| <input type="checkbox"/> Other (specify) _____ |  |   |

## EATING/SLEEPING

Please check any of the items below that you feel describe the minor's behavior:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Nightmares            | <input type="checkbox"/> Trouble falling asleep | <input type="checkbox"/> Wets the bed              |
| <input type="checkbox"/> Good appetite         | <input type="checkbox"/> Eats too much          | <input type="checkbox"/> Grinds teeth during sleep |
| <input type="checkbox"/> Other (specify) _____ |   |  |

## PERSONALITY

Please check any of the items below that you feel describe the minor's behavior:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dependable    | <input type="checkbox"/> Good sense of humor | <input type="checkbox"/> Independent           |
| <input type="checkbox"/> Truthful      | <input type="checkbox"/> Energetic           | <input type="checkbox"/> Wants to be perfect   |
| <input type="checkbox"/> Acts immature | <input type="checkbox"/> Disobedient         | <input type="checkbox"/> Other (specify) _____ |

## BEHAVIOR PROBLEMS

Please check any of the items below that you feel describe the minor's behavior:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Difficulty paying attention | <input type="checkbox"/> Easily distracted    | <input type="checkbox"/> Disorganized          |
| <input type="checkbox"/> Daydreams often             | <input type="checkbox"/> Hyperactive          | <input type="checkbox"/> Trouble sitting still |
| <input type="checkbox"/> Impulsive                   | <input type="checkbox"/> Can't complete tasks | <input type="checkbox"/> Lies                  |
| <input type="checkbox"/> Steals                      | <input type="checkbox"/> Sets fires           | <input type="checkbox"/> Uses drugs            |
| <input type="checkbox"/> Aggressive                  | <input type="checkbox"/> Frustrates easily    | <input type="checkbox"/> Acts young for age    |
| <input type="checkbox"/> Excitable                   | <input type="checkbox"/> Stubborn             | <input type="checkbox"/> Poor coordination     |
| <input type="checkbox"/> Other (specify) _____       |   |  |