

CHILD/ADOLESCENT PERSONAL HISTORY

PLEASE COMPLETE AND BRING THIS FORM TO YOUR CHILD/ADOLESCENT'S INITIAL APPOINTMENT. This information request is treated as CONFIDENTIAL. The questions are designed to help us understand your concerns about your child or adolescent so that we may be able to assist you. If you have any questions about the requested information, please do not hesitate to ask.

Child's Name: _____

Date: _____

Therapist: Vladimir Vandalov, PsyD

Is the child/adolescent adopted? No Yes

If Yes, at what age was he/she adopted? _____

If Yes, does he/she know of the adoption? _____

Has this child ever been placed outside the home? No Yes

Please list all persons living in the home with the child/adolescent.

Name of Current Resident	Age	Relationship to Child/Adolescent
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the child/adolescent's hobbies and interests:

Number of: Close friends _____ Acquaintances _____ Pets _____ What Kind: _____

Any difficulty in social situations?

OTHER FAMILY INFORMATION

Check which of the following apply to the child/adolescent's parents:

Married Separated Divorced

Living Together Never married nor lived together

PROBLEM BEHAVIORS

Please check any of the behaviors that occur excessively.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Worries | <input type="checkbox"/> Skipping classes/School | <input type="checkbox"/> Cruelty to Animals | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Reckless Behavior | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Obsessive thoughts | <input type="checkbox"/> Runs Away from Home | <input type="checkbox"/> Disruptive Behavior | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Compulsive Behavior | <input type="checkbox"/> Tantrums, Angry Outbursts | <input type="checkbox"/> Messy | <input type="checkbox"/> Crying Spells |
| <input type="checkbox"/> Odd Thoughts | <input type="checkbox"/> Bullies | <input type="checkbox"/> Accident Prone | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Odd Behavior | <input type="checkbox"/> Argues | <input type="checkbox"/> Short Attention Span | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Disturbing Thoughts | <input type="checkbox"/> Defiant / Oppositional | <input type="checkbox"/> Distractible | <input type="checkbox"/> Boredom |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Fights | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Significant Appetite Change |
| <input type="checkbox"/> Night terrors | <input type="checkbox"/> Lies | <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Missing School Due to Illness |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Steals | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Frequent Physical Complaints |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Destroys property | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Sexual Activity |
| <input type="checkbox"/> Will Not Sleep Alone | <input type="checkbox"/> Sets Fires | <input type="checkbox"/> Poor School Work | <input type="checkbox"/> Clinging / Dependent |
| | | | <input type="checkbox"/> Unmotivated
(School, Job) |

SIGNIFICANT LIFE EVENTS

- Please check any of the following events which have occurred in your child/adolescent’s life and his/her age when it occurred.

✓ Event or Situation	Age	✓ Event or Situation	Age
<input type="checkbox"/> Change of residence	_____	<input type="checkbox"/> Family gambling problems	_____
<input type="checkbox"/> Change of schools	_____	<input type="checkbox"/> Family psychiatric problems	_____
<input type="checkbox"/> Change of custody	_____	<input type="checkbox"/> Family chronic illness	_____
<input type="checkbox"/> Martial conflict	_____	<input type="checkbox"/> Other family problems	_____
<input type="checkbox"/> Parents separated	_____	<input type="checkbox"/> Rejection by family member(s)	_____
<input type="checkbox"/> Parents divorced	_____	<input type="checkbox"/> Abuse to self(verbal, physical, sexual)	_____
<input type="checkbox"/> Parent visitation problems	_____	<input type="checkbox"/> Witnessed abuse to others	_____
<input type="checkbox"/> Post divorce parent conflict	_____	<input type="checkbox"/> Victim of abuse	_____
<input type="checkbox"/> Parent(s) remarried	_____	<input type="checkbox"/> Suffered/Witnessed significant accident or injury	_____
<input type="checkbox"/> Step parent problems	_____	<input type="checkbox"/> Other severe fright or trauma	_____
<input type="checkbox"/> Sibling birth	_____	<input type="checkbox"/> Death of family member or friend	_____
<input type="checkbox"/> Acquired step sibling(s)	_____	<input type="checkbox"/> Suicide of family member or friend	_____
<input type="checkbox"/> Family economic problems	_____	<input type="checkbox"/> Death of pet	_____
<input type="checkbox"/> Family job problems	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Family Substance abuse	_____		

Please write in the school district attended by your child/adolescent for each grade, and the usual marks attained. Check any of the problems listed for each of the grades in which they occurred.

Grade	School District	Academic Grades	Learning Problems	Peer Problems	Short Attention Span	Hyperactivity	Behavior Problems	Expelled Suspended
K	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LEGAL HISTORY

If your son/daughter is on probation, please provide the name, address, and phone number of his/her probation officer.

Name: _____

Address: _____

Phone: (____) _____

Zip Code: _____

MEDICAL HISTORY

Please check any of the following medical or physical conditions that apply to your child/adolescent.

- | | | |
|--|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chronic Ear Infection | <input type="checkbox"/> Frequent Stomach Aches | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Febrile Seizures | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Tics (Twitches) |
| <input type="checkbox"/> Menstruation Stopped | <input type="checkbox"/> Gross Motor Problems | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Frequent Vomiting | <input type="checkbox"/> Failure to Thrive |
| <input type="checkbox"/> Fine Motor Problems | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Growth Retardation | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Cardiac Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> History of Migraines |
| <input type="checkbox"/> Eating Disorder | | |

- Has your child/adolescent been hospitalized for medical treatment? No Yes
If Yes, when and for the treatment of what condition.

SIGNATURES

Relationship of Adult Completing Form of the child/adolescent to be seen in clinic:

Parent Foster Parent Guardian Other: _____

Signature of Adult Completing Form

Date

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM
The Clinician you see for this initial evaluation will go over this form with you as part of the assessment process in an effort to better understand your concerns regarding your child/adolescent .