

## History – Child/Adolescent Form

### Demographic Information

Name of Child/Adolescent being evaluated: \_\_\_\_\_

D.O.B. \_\_\_\_\_ Age \_\_\_\_\_

Name of person filling out form: \_\_\_\_\_

Relationship to client \_\_\_\_\_

Permanent Home Address \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

### Child History

Purpose of evaluation request:

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In your own words, please describe how your child has been functioning (in general) over the past 6 months. Please include what is going well and what he/she has been having difficulty with:

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Birth History:

1. Place of birth \_\_\_\_\_
2. Vaginal Birth \_\_\_\_\_ Cesarean Section \_\_\_\_\_
3. On-time delivery  
\_\_\_\_ Yes  
\_\_\_\_ No, please describe \_\_\_\_\_
4. Complications with labor or delivery:  
\_\_\_\_ None  
\_\_\_\_ Yes, if so, please describe

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5. Did your child suffer any significant illness the first year of life?  
\_\_\_\_ None  
\_\_\_\_ Yes, please describe

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Developmental Milestones:

1. Please list the approximate onset of the following:

First words \_\_\_\_\_

Talking \_\_\_\_\_

Walking \_\_\_\_\_

Potty Training \_\_\_\_\_

2. Was your child a bed wetter? If so, please describe:

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3. Below is a brief description of various aspects of development. Please describe if you noticed any atypical development in any of these areas

- **Gross motor:** using large groups of muscles to sit, stand, walk, run, etc., keeping balance, and changing positions.

\_\_\_ No

\_\_\_ Yes, if so, please describe:

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- **Fine motor:** using hands to be able to eat, draw, dress, play, write, and do many other things.

\_\_\_ No

\_\_\_ Yes, please describe:

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- **Language:** speaking, using body language and gestures, communicating, and understanding what others say.

No

**Yes, please describe**

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- **Cognitive:** Thinking skills: including learning, understanding, problem-solving, reasoning, and remembering.

No

**Yes, please describe**

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- **Social:** Interacting with others, having relationships with family, friends, and teachers, cooperating, and responding to the feelings of others.

No

**Yes, please describe**

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- **Emotional:** Frustration tolerance, expressing happiness, sadness, anger; learning to manage temper in appropriate ways.

No

**Yes, please describe**

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Academic Functioning

1. Name and location of current school

\_\_\_\_\_

2. Private or public? \_\_\_\_\_

If private, does the school specialize in a certain area and if so, please describe

\_\_\_\_\_

\_\_\_\_\_

3. Has your child ever been held back?

No

Yes, please explain \_\_\_\_\_

\_\_\_\_\_

4. Has your child ever required private tutoring or special education?

No

Yes, please explain \_\_\_\_\_

\_\_\_\_\_

5. Has your child ever required special academic accommodations?

No

yes, please explain \_\_\_\_\_

\_\_\_\_\_

6. Please briefly describe any other academic difficulties not captured above:

\_\_\_\_\_

\_\_\_\_\_

7. Approximate grades:
- Kindergarten \_\_\_\_\_
- 1<sup>st</sup> grade \_\_\_\_\_
- 2<sup>nd</sup> grade \_\_\_\_\_
- 3<sup>rd</sup> grade \_\_\_\_\_
- 4<sup>th</sup> grade \_\_\_\_\_
- 5<sup>th</sup> grade \_\_\_\_\_
- Middle School \_\_\_\_\_
- High School \_\_\_\_\_

8. Please check any of the following that apply to your child. If you check an item, please list the age range that your child exhibited each behavior:

	No	Yes	Age range
a) frequent anger outbursts	_____	_____	_____
b) distractibility	_____	_____	_____
c) forgetfulness	_____	_____	_____
d) difficulty completing tasks	_____	_____	_____
e) difficulty staying seated	_____	_____	_____
f) makes careless mistakes	_____	_____	_____
g) doesn't listen	_____	_____	_____
h) disorganized	_____	_____	_____
i) difficulty concentrating	_____	_____	_____
j) loses things	_____	_____	_____
k) Anxious, worrying	_____	_____	_____
l) Frequent irritability	_____	_____	_____
m) hitting self	_____	_____	_____
n) hitting others	_____	_____	_____
o) oppositional to parents	_____	_____	_____
p) oppositional to teachers	_____	_____	_____
q) talking too much	_____	_____	_____
r) skipping school	_____	_____	_____
s) stealing	_____	_____	_____

Psychiatric History

1. Has your child ever been diagnosed with a psychiatric or developmental disorder?

No

Yes, Please list disorder and age of onset:

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2. Has your child ever received outpatient psychiatric treatment?

No

Yes, please describe

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3. Has your child ever received inpatient psychiatric treatment?

No

Yes, please describe

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4. Has your child ever displayed the following? If yes, please describe

	No	Yes	
a) suicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
b) suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
c) homicidal ideation	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
d) visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
e) auditory hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
f) paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

- g) delusions \_\_\_\_\_
- h) restricted interests \_\_\_\_\_
- i) sensitivity to noise \_\_\_\_\_

Medical History

1. Illness history (please include surgeries)

Illness	Age	Duration	Medical Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please use back of page if you require more room

2. Has your child ever experienced seizures?

- \_\_\_\_\_ No
- \_\_\_\_\_ Yes, describe \_\_\_\_\_

3. Has your child ever experienced a head injury (including “getting their bell rung”)

- \_\_\_\_\_ No
- \_\_\_\_\_ Yes, please describe (loss of consciousness? Continued difficulties following? Medical work up? )

4. Does your child currently or has he/she ever suffer from frequent headaches?

- \_\_\_\_\_ No
- \_\_\_\_\_ Yes, please describe \_\_\_\_\_

5. Does your child have problems with hearing?

No

Yes, please describe \_\_\_\_\_

6. Does your child have problems with vision or wear glasses?

No

Yes, please describe \_\_\_\_\_

7. Medications

Please list any prescribed medications your child has taken in the past 5 years

Name of medication	highest dose taken	Duration of medication trial
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please use back of page if you require more room

8. Physicians:

Primary Care Physician \_\_\_\_\_

Affiliated hospital \_\_\_\_\_

Has your child ever been evaluated by a neurologist?

No

Yes

If yes,

What was the referral question? \_\_\_\_\_

What tests were performed (i.e., MRI, EEG)? \_\_\_\_\_

What were the results? \_\_\_\_\_

Diagnosis given? \_\_\_\_\_

9. Does your child have, or have the ever been evaluated by a specialist?

No

Yes, If yes, please list below:

Name	Affiliated Hospital	Date
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\_\_\_\_\_

\_\_\_\_\_

10. To your knowledge, has your child ever experimented or used drugs or alcohol?

- No  
 Don't Know  
 Yes, please describe

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous Neuropsychological or Psychological Evaluations:

Has your child ever received a previous evaluation? Please list below. If you don't have a copy for review, please describe the results below.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Immediate Family History**

Father's Name: \_\_\_\_\_

Relationship:  Biological  Adoptive  
DOB \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_  
Highest level of education \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Relationship:  Biological  Adoptive  
DOB \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Highest level of education \_\_\_\_\_

Year of Marriage \_\_\_\_\_ If not married, how long have you been with your partner?  
\_\_\_\_\_

Does the client's biological mother or father have any remarkable medical (including neurological) or psychiatric history, learning issues, or other issues that might be relevant? If so, please describe: \_\_\_\_\_

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### Extended Family History

Medical or Neurological History (please list any known medical conditions as well as the relative, i.e., maternal grandmother of client, paternal uncle of father, etc):

Psychiatric History:

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**SUSAN PARKS, PH.D.**  
LICENSED PSYCHOLOGIST  
NEUROPSYCHOLOGIST

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Medical History:

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Thank you for your time and careful attention.

Please use the remaining space to describe any additional features that you feel are important, but not captured in this form:

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