

CHILD AND ADOLESCENT EVALUATION: PATIENT FORM

Page 2

Patient: _____ Date: _____ Provider: _____

Developmental History

Pregnancy /neonatal/ infancy:

Were there complications with the pregnancy or your child's delivery (for instance, medications, prematurity, fetal distress, low Apgars, C-section)?
Were there any medical problems in the first two years of life?

Developmental milestones and concerns:

Did/does your child have problems with the following developmental milestones?
Please note the dates you had concerns about the problem.

Feeding concerns? _____

Breast Feed? How long? _____

Physical growth problems? _____

Colic? _____

Sleep habits? _____

Sleep through the night? _____

Sleeping alone? _____

Age of walking? _____

Clumsiness? _____

Age of first words, first sentences? _____

Other language concerns? _____

Age of bowel training? Current Soiling? _____

Age of bladder training? Current wetting? _____

Hygiene concerns? _____

Problems separating from parents? _____

Past and current peer relations? _____

What do you see as your child's strengths and weaknesses?

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Page 3

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School History

What is your child's grade and school?

What other schools has he/she attended?

Has your child been in special education? Have there been learning problems? Give details of problems and supports.

Do you have concerns about the school program?

Has there been psychological testing? When? Results? Bring to the evaluation if available.

What is your child's attitude toward school?

What are your hopes for your child's educational attainment and vocational future?

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Social History

List the names, ages, and occupations/grades of family members in the current household.

List immediate relatives (biological or related by marriage, parents or siblings) or other primary caretakers (sitters, day care) of the child outside the primary home. Has there been any significant history of problems with caretakers, such as abuse or neglect?

Are there any particular stresses or recent changes in the family such as job changes, financial problems, school changes, health problems, marriage or divorce, violence, or substance abuse?

Who is responsible for disciplining? What methods work or haven't worked? Do caregivers/parents agree on discipline? Is there allowance? Are there chores?

How well I does your child get along

with siblings? _____

with peers? _____

with parents? _____

by himself/herself? _____

What are family activities or mealtimes like? Does your child have other activities or hobbies? Favorite TV or movies?

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Page 6

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Family History

Please identify if there is a history of the following problems in the **child's genetic or natural family**, and indicate briefly the problem and relative (for example, seizures in a maternal aunt).

Alcohol or drug problems in family members

Eating problems in family members

ADHD or school behavior problems in family members

Conduct problems or court involvement in family members

Mental retardation, learning, disabilities, or other developmental problems

Mood problems, including suicide, depression, or manic-depressive illness, treated or untreated in family members

Anxiety and panic problems in family members

Schizophrenia in family members _____

Neurologic problems such as seizures, or migraines

Tics or Tourette disorder _____

Thyroid problems in family members _____

Genetic syndromes in family members _____

Cardiac or other medical problems in family members

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PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

- | | |
|---|---|
| <input type="checkbox"/> careless / poor attention to details | <input type="checkbox"/> fidgets |
| <input type="checkbox"/> difficulty sustaining attention | <input type="checkbox"/> leaves seat |
| <input type="checkbox"/> doesn't listen | <input type="checkbox"/> runs about / subjectively restless |
| <input type="checkbox"/> doesn't follow through with requests | <input type="checkbox"/> difficulty playing quietly |
| <input type="checkbox"/> difficulty organizing | <input type="checkbox"/> "On the go" / "motor driven" |
| <input type="checkbox"/> avoids effortful tasks | <input type="checkbox"/> excessive talk |
| <input type="checkbox"/> loses necessary things | <input type="checkbox"/> blurts out answers |
| <input type="checkbox"/> easily distracted | <input type="checkbox"/> difficulty waiting turn |
| <input type="checkbox"/> forgetful in daily activities | <input type="checkbox"/> interrupts/intrudes |

Where are these problems present, in the home, in the school, or in other settings?
Comments:

- | | |
|-------------------------------------|---|
| stealing in the home or out of home | cruelty to animals |
| lying | legal involvement with juvenile services |
| truancy/runaway | inappropriate sexual interests and behavior |
| violence in the family | lack of conscience |
| violence at school | threats of violence |
| violence in the community | exceptional negativity to rules |
| fire setting or fireplay | |

Comments:

- | | |
|---------------|---------------------|
| alcohol use | cigarette use |
| marijuana use | other substance use |

Comments:

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PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

- expresses depression or hopelessness or low self esteem
- can be irritable or giddy or elated inappropriately
- hypersexual or loss of other inhibitions
- mood swings (circle period of change MINUTES, HOURS, DAYS, WEEKS, or MONTHS)
- moods change without reason
- lack of interest in friends or normal activities
- poor sleep or excessive sleep
- poor eating or excessive eating or concerns over weight changes or dieting
- binging with or without purging (self induced vomiting)
- suicidal talk or acts of self harm or mutilation

Comments:

- school refusal or excessive absences
- anxiety at bedtime or in the night / refusal to sleep alone
- fears of harm to family members
- complaints of physical symptoms such as headache or stomach ache
- specific phobias (heights, spiders, etc.)
- sudden feelings of panic
- refusal to speak in public, or refusal to go out in public
- history of trauma (abuse, accident, etc.)
- nail biting, thumb sucking, teeth grinding, hair pulling, skin picking
- excessive hand washing, or repetitive touching, or checking, or other "rituals"
- overconcern regarding germs, illnesses, contamination by dirt, or other obsessive thoughts
- overly perfectionistic

Comments:

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PLEASE CIRCLE AND COMMENT AS APPROPRIATE:

- tics or twitches of the mouth, eyes, facial muscles, or arms and legs
- head banging or rocking
- other repetitive behaviors causing self injury (biting, scratching, etc.)
- other repetitive movements such as jumping or arm/hand flapping or spinning
- lack of affection (doesn't seek out or provide comfort)
- little need for reassurance in a strange situation, or little stranger anxiety
- poor peer relations/ no real friends
- problems understanding feelings of others during interactions
- distress over changes in routine
- unusual toy or play interests (collections, string, line up or take apart toys rather than play)
- restricted conversational interests (dinosaurs or specific topics to the exclusion of other topics)

hoarding food or other objects

Comments:

odd thinking or peculiar ideas

difficulty discerning what is real vs. normal fantasy play

paranoid thinking

hearing voices

seeing things not there

periods of odd sensations or loss of memory for a period of time

PLEASE ALSO COMMENT BELOW IF YOU HAVE OTHER CONCERNS NOT RAISED IN THE PREVIOUS SEVERAL PAGES

Comments:

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