Douglasville Psychotherapy Center at Oakhill, P.C.

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CHILD/ADOLESCENT PSYCHOSOCIAL (Ages 3-11 years)

IDENTIFYING INFORMATION

Date of Initial Appointment _____

Name of child _____ Sex _____

Birthdate _____ Place of birth _____ Age _____

Address (number and street) _____

City _____ State _____ Zip _____

Telephone _____ Religion (optional) _____

Education (grade) _____ Present school _____

Referral Source _____

Adult completing form _____ Relationship _____

CHIEF COMPLAINT

Presenting Problems (check all that apply)

_____Very unhappy	_____Impulsive	_____Fire setting	_____Irritable
_____Stubborn	_____Stealing	_____Temper outbursts	
_____Disobedient	_____Lying	_____Withdrawn	_____Infantile
_____Sexual trouble	_____Daydreaming	_____Mean to others	
_____School performance	_____Fearful	_____Destructive	_____Truancy
_____Clumsy	_____Bed wetting	_____Trouble with the law	
_____Overactive	_____Running away	_____Soiled pants	_____Slow
_____Self-mutilating	_____Distractible	_____Rocking	_____Eating problems
_____Sickly	_____Lacks initiative	_____Shy	_____Drug use
_____Undependable	_____Alcohol use	_____Strange behavior	_____Peer conflict
_____Strange thoughts	_____Suicide talk	_____Aggressive toward others	

How long have these problems occurred? (Number of weeks, months, years) _____

_____

What happened that makes you seek help at this time? _____

_____

Problems perceived to be: Very serious _____ Serious _____ Not serious _____

What are your expectations of your child? _____

What changes would you like to see in your child? _____

_____

What changes would you like to see in yourself? _____

_____

What changes would you like to see in your family? _____

_____

PSYCHOSOCIAL HISTORY

Current Family Situation

Biological Mother's Name: _____ Age: _____

Stepmother's Name: _____ Age: _____

Adoptive Mother's Name: _____ Age: _____

Biological Father's Name: _____ Age: _____

Stepfather's Name: _____ Age: _____

Adoptive Father's Name: _____ Age: _____

MARITAL HISTORY OF PARENTS

Natural Parents:	_____Married	When _____	Ages _____, _____
	_____Separated	When _____	
	_____Divorced	When _____	
	_____Deceased	When _____	M or F _____
Step Parents	_____Married	When _____	
	_____Separated	When _____	
	_____Divorced	When _____	

If Child is Adopted:

Adoptive Source _____

Reason and circumstances _____

Age when child first came into home _____

Date of legal adoption _____

What has the child been told _____

LIVING ARRANGEMENTS

Number of moves in child's life _____

Places and Dates _____

_____

Present Home (Renting or Buying) _____

Apartment or House _____

Does the child share a room with anyone else _____ If no, how long has child had own space _____

Was the child ever places, boarded or lived away from the family _____

Explain _____

What are the major family stressors at the present time, if any _____

_____

What are the sources of family income _____

_____

List All Individuals Living In the Home:

Name	Relationship	Age	Sex	School Present grade	Living at home	Uses Drugs

HEALTH OF FAMILY MEMBERS

List other extended family members by their relationship to the patient and/if they have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

Name: _____ Relationship: _____ Type of Issue: _____

Name: _____ Relationship: _____ Type of Issue: _____

Name: _____ Relationship: _____ Type of Issue: _____

Does or did any member of the child's family have any problems with:

_____Reading _____Spelling _____Math _____Speech

If yes, explain _____

Is there any history in the child's family of:

_____Mental retardation _____Epilepsy _____Birth defects _____Schizophrenia

If yes, explain _____

CHILD HEALTH INFORMATION

Note all health problems the child has had or has now

Symptom	Age	Symptom	Age
_____High fever	_____	_____Dental problems	_____
_____Pneumonia	_____	_____Weight problems	_____
_____Flu	_____	_____Allergies	_____
_____Encephalitis	_____	_____Skin problems	_____
_____Meningitis	_____	_____Asthma	_____
_____Convulsions	_____	_____Headaches	_____
_____Unconsciousness	_____	_____Stomach problems	_____
_____Concussions	_____	_____Accident prone	_____
_____Head injury	_____	_____Anemia	_____
_____Fainting	_____	_____High or low blood pressure	_____
_____Dizziness	_____	_____Sinus problems	_____
_____Tonsils out	_____	_____Heart problems	_____
_____Vision problems	_____	_____Hyperactivity	_____
_____Hearing problems	_____	_____Earaches	_____
_____Other problems	_____		

Explain _____

_____

Has the child ever been hospitalized? Yes _____ No _____

If yes, when and for how long _____

_____

Has the child ever been seen by a medical specialist? Yes _____ No _____

If yes, explain _____

_____

Has the child ever taken or is he/she currently taking any prescribed medications? Yes _____ No _____

If yes, explain _____

_____

Name of Primary Care Physician _____

DEVELOPMENTAL HISTORY

Pregnancy/Child Wanted? Yes _____ No _____ Planned for? Yes _____ No _____

Normal pregnancy? Yes _____ No_____

Was mother ill during pregnancy? Yes _____ No _____ Explain _____

_____

Length of pregnancy _____ Parental support and acceptance _____

BIRTH

Length of active labor _____ Easy _____ Difficult _____

Full term? Yes _____ No _____ If premature, how early _____

If overdue, how long _____

Birth weight _____ Type of delivery _____ Head first _____ Breech _____

Was is necessary to give the infant oxygen? Yes _____ No _____ For how long _____

Did the infant require blood transfusions? Yes _____ No _____

Did the infant require X-rays? Yes _____ No _____

Physical condition of infant at birth _____

Did the mother abuse alcohol/drugs during pregnancy? Yes _____ No _____ For how long _____

Did the mother use tobacco during pregnancy? Yes _____ No _____ For how long _____

NEWBORN PERIOD

Symptom	Yes	No
Irritability	_____	_____
Vomiting	_____	_____
Difficulty breathing	_____	_____
Difficulty sleeping	_____	_____
Convulsions/twitching	_____	_____
Colic	_____	_____
Normal weight gain	_____	_____
Was child breast fed	_____	_____

DEVELOPMENTAL MILESTONES

Age at which the child:

Sat up _____
Crawled _____
Walked _____
Spoke single words _____
Sentences _____
Bladder trained _____
Bowel trained _____
Weaned _____

Describe the manner in which toilet training was accomplished _____

_____

EARLY SOCIAL DEVELOPMENT

Relationship to siblings and peers

_____Individual play
_____Competitive
_____Leadership role
_____Group play
_____Cooperative
_____A follower

Describe special habits, fears, or idiosyncrasies of the child _____

_____

Educational History

	Name	City/State	Dates attended	Grade completed
Preschool				
Elementary				
Junior High				
High School				

Type of classes? Regular _____ Learning Disability _____ Continuation _____
Emotionally Handicapped _____ Opportunity _____
Did the child skip grades? Yes _____ No _____ Which grade _____
Did the child repeat a grade? Yes _____ No _____ Which grade _____
Does the child have specific learning disabilities? _____
Has the child ever had a tutor or other special help with school? _____
Does the child attend school on a regular basis? Yes _____ No _____
Does the child appear motivated for school? Yes _____ No _____
Has the child ever been suspended or expelled? Yes _____ No _____

RECREATIONAL:

How does your child spend his/her time?

_____

_____

What hobbies does your child enjoy?

_____

How often does your child play:

By himself or herself? _____

With his/her friends? _____

With family? _____

What was the most fun your child has ever had?

_____

When was your child happiest?

_____

What type of physical activity is your child involved in?

_____

What activities do you do with your child? _____

_____

TREATMENT GOALS:

In looking at your child's current situation, in what areas would you like to see improvement? Please check all that apply and add more if needed.

____Anger Control	____Stress Management	____Fair Fighting
____Communication Skills	____Problem Solving	____Parenting
____Increasing Flexibility	____Assertiveness Skills	____Decision Making
____Socially Comfortable	____Financial Management	____Self Esteem

Any additional treatment goals for your child:

_____

_____

_____

ACADEMIC PERFORMANCE

Highest grade on last report card _____
Lowest grade on last report card _____
Favorite subject _____
Least favorite subject _____
Does child participate in extracurricular activities? Yes _____ No _____ Which ones _____
_____

In school, how many friends does the child have? _____

What are the child's educational aspirations? _____

Has the child had special testing in school? Yes _____ No _____ Explain _____
_____

List the child's special interests hobbies, skills
_____
_____
_____

Has the child ever had difficulty with the police? Yes _____ No _____ When _____

Has the child ever appeared in juvenile court? Yes _____ No _____ When _____

Has the child ever been on probation? Yes _____ No _____ When and for how long _____
_____

Has the child ever been employed? Yes _____ No _____ Where and for how long _____
_____

CULTURAL CONSIDERATIONS

_____
_____
_____

ADDITIONAL COMMENTS

_____
_____
_____
_____

Sentence Completion

Date _____

Patient Name _____

I would like to _____

Tomorrow I will _____

My mother _____

I cannot _____

I wish that I _____

If I only _____

I worry about _____

Girls _____

I am ashamed _____

I am afraid _____

I hope _____

My father _____

I like _____

I don't like _____

In school I _____

I love _____

Boys _____

It isn't nice to _____

A mother should _____

My teacher _____

There are times when _____

I hate _____

Parent's Questionnaire

Date _____

Name of child _____ Age _____

Name of parent (filing out form) _____

Answer all of the questions by indicating the degree of the problem. Write" N" for never, "S" for sometimes, or "O" for often in front of the number for each question.

Questions

_____ 1. Picks at things (nails, fingers, hair, clothing)

_____ 2. Talks back to authority figures (attitude)

_____ 3. Has problems with making or keeping friends

_____ 4. Excitable, impulsive

_____ 5. Wants to run things

_____ 6. Sucks or chews (thumbs, clothing, blankets, etc)

_____ 7. Cries easily/often

_____ 8. Emotionally reactive

_____ 9. Has a chip on his/her shoulder

____ 10. Tendency to daydream

____ 11. Always squirming, restless, and moving around

____ 12. Difficulty learning

____ 13. Experiences fear and anxiety in new situations/meeting new people

____ 14. Breaks things/destructive

____15. Lies, makes up stories

____ 16. Does not follow the rules

____ 17. Gets into trouble more than peers

____ 18. Shy and does not assert self

____ 19. Has problems with speech (stuttering, hard to understand baby talk)

____ 20. Denies mistakes and is defensive

____ 21. Blames others for mistakes

____ 22. Steals

____ 23. Argumentative

____ 24. Disrespectful

____ 25. Pouts and sulks

____ 26. Obeys rules but is resentful

____ 27. When hurt or angered by someone, holds a grudge

____ 28. Develops stomach-ache or head-ache when stressed

____ 29. Worries unnecessarily

____ 30. Does not finish tasks

____ 31. Emotionally sensitive and easily hurt

____ 32. Bullies others

____ 33. Cruel and insensitive

____ 34. Clingy and in need of constant reassurance

____ 35. Easily distracted

____ 36. Frequent head-aches or stomach-aches

____ 37. Rapid mood changes

____ 38. Fights a lot and creates conflicts

____ 39. Power struggles with authority

____ 40. Childish or immature and wants help when should be able to do it independently

____ 41. Does not get along well with siblings

____ 42. Easily frustrated

____ 43. Perfectionism prevents trying new things

____ 44. Problems with sleep

____ 45. Problems with eating

____ 46. Has bowel problems

____ 47. Vomiting, nausea, or other complaints of pain or physical distress

____ 48. Feeling he/she is treated differently in the family than siblings

____ 49. Passive and gets pushed around

____ 50. Self-centered, brags, little understanding of others