PREMIER PSYCHOLOGICAL SERVICES

CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY

Today's Date: _____

Name of Child: _____ Sex: (M) ____ (F) ____

Date Of Birth: _____ Place of Birth: _____ Age: _____

Address (number and street): _____

City: _____ State: _____ Zip Code: _____

Telephone: ( )_____Email:_____

Education (grade): _____ Present School: _____

Referral Source: _____

Mother's Name: _____ DOB: _____

Home Phone: _____ Address: _____

Employed as: _____ Work Phone: _____

Father's Name: _____ DOB: _____

Home Phone: _____ Address: _____

Employed as: _____ Work Phone: _____

Step-Parent's Name: _____ DOB: _____

Home Phone: _____ Address: _____

Employed as: _____ Work Phone: _____

I give permission for the office staff and the clinicians at PPS to contact and release to my child's pediatrician(name)_____ clinical notes and reports regarding treatment issues, symptoms, behaviors or other information necessary for the treatment of my child.

Parent Signature: _____ Date: _____

The River Oaks Tower
3730 Kirby Drive, Suite 800
Houston, TX 77098
713-521-7575
713-521-7576 fax
www.premierpsychservices.com

CHIEF COMPLAINT

Presenting Problems: (check all that apply)

___ Very unhappy
___ Irritable
___ Temper outbursts
___ Withdrawn
___ Daydreaming
___ Fearful
___ Clumsy
___ Overactive
___ Slow
___ Short attention span
___ Distractible
___ Lacks initiative
___ Undependable
___ Peer conflict
___ Phobic
___ Dependency on illegal, prescribed, or over the counter drugs
___ Impulsive
___ Stubborn
___ Disobedient
___ Infantile
___ Mean to others
___ Destructive
___ Trouble with the law
___ Running away
___ Self-mutilating
___ Head banging
___ Rocking
___ Shy
___ Strange behavior
___ Strange thoughts
___ Suicide talk
___ Fire-setting
___ Stealing
___ Lying
___ Sexual trouble
___ School performance
___ Truancy
___ Bed-wetting
___ Soiled pants
___ Eating problems
___ Sleeping problems
___ Sickly
___ Tobacco use
___ Alcohol use
___Learning problems

Explain:

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? _____

_____

Religion or cultural affiliations that may affect therapy _____

_____

PSYCHOSOCIAL HISTORY

Current Family Situation:

Mother – Relationship to child:

__ natural parent __ relative
__ stepparent __ adoptive parent

Occupation: _____

Education: _____ Religion: _____

Birthplace: _____ Birthdate: _____

Age: _____

Father – Relationship to child:

__ natural parent __ relative
__ stepparent __ adoptive parent

Occupation: _____

Education: _____ Religion: _____

Birthplace: _____ Birthdate: _____

Age: _____

Marital History of Parents:

Natural Parents: __ married when _____ age _____ _____
__ separated when _____
__ divorced when _____
__ deceased Mother or Father _____

Stepparents:
__ married when _____
__ married when _____

If child is adopted:

Adoption source: _____

Reason and circumstances: _____

Age when child first in home: _____

Date of legal adoption: _____

What has the child been told? _____

Living Arrangements: Places Dates

Number of moves in child's life _____ _____
_____ _____
_____ _____

Present Home __ renting __ buying _____ _____
__ house __ apartment _____ _____

Does the child share a room with anyone else? __ Yes __ No

If yes, with whom? _____

If no, how long has he/she had own room? _____

Was the child ever placed, boarded, or lived away from the family? __ Yes __ No
Explain: _____

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

Brothers and Sisters: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use drugs or alcohol (yes or no)	Treated for drug abuse (yes or no)
1.							
2.							
3.							
4.							
5.							
6.							

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

1. _____
2. _____
3. _____
4. _____
5. _____

Others living in the home (and their relationship):

1. _____
2. _____

Health of Family Members: (excluding patient)

Name	Relationship to child	Type of illness	When occurred	Length of illness
1.				
2.				
3.				
4.				

Does or did any member of the child's family have any problems with:
____ reading ____ spelling ____ math _____ speech
(If yes, please explain)

Is there any history in the child's family of:
____ mental illness ____ epilepsy ____ birth defects _____ schizophrenia
(If yes, please explain)

Child Health Information: Note all health problems the child has had or has now.

	AGE		AGE
__ High fevers	_____	__ 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 press.	_____
__ Dizziness	_____	__ Sinus problems	_____
__ Tonsils out	_____	__ Heart problems	_____
__ Vision problems	_____	__ Hyperactivity	_____
__ Hearing problems	_____	__ Other illnesses (explain)	_____
__ Earaches	_____		
__ Infectious diseases (explain)			

Has the child ever been hospitalized? ___ Yes ___ No
(If yes, please explain)

Age How Long Reason
_____ _____ _____

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

Age	How Long	Reason
_____	_____	_____

Has child ever taken, or is he/she taking presently, any prescribed medications? ___ Yes ___ No

Age	How Long	Reason
_____	_____	_____

Name of Primary Care Physician: _____

Developmental History:

PRENATAL – Child wanted? ___ Yes ___ No Planned for? ___ Yes ___ No
Normal pregnancy? ___ Yes ___ No
If mother ill or upset during pregnancy, please explain:

Length of pregnancy: _____
Paternal support and acceptance: (explain)

BIRTH – Length of active labor: _____ hrs. _____ Easy _____ Difficult

Full term: ____ Yes ___ No

If premature, how early: _____

If overdue, how late: _____

Birth weight: _____ lbs. _____ oz.

Type of delivery: __ spontaneous __ cesarean __ with instruments
__ head first __ breech

Was it necessary to give the infant oxygen? ___ Yes ___ No If yes, how long? _____

Did infant require blood transfusion? ___ Yes ___ No

Did infant require x-ray? ___ Yes ___ No

Physical condition of infant at birth:

(If yes, explain)			
	anorexia	___ Yes	___ No
	trauma	___ Yes	___ No
	other complications	___ Yes	___ No

Did mother use/abuse alcohol/drugs during pregnancy? ___ Yes ___ No

NEWBORN PERIOD –

			How Long?
Irritability	___ Yes	___ No	_____
Vomiting	___ Yes	___ No	_____
Difficulty breathing	___ Yes	___ No	_____
Difficulty sleeping	___ Yes	___ No	_____
Convulsions/twitching	___ Yes	___ No	_____
Colic	___ Yes	___ No	_____
Normal weight gain	___ Yes	___ No	_____
Was child breast-fed	___ Yes	___ No	_____

DEVELOPMENTAL MILESTONES – Age at which child:

Sat up: _____ Bladder trained: _____

Crawled: _____ Bowel trained: _____

Walked: _____ Weaned: _____

Spoke single words: _____ Sentences: _____

Describe the manner in which toilet training was accomplished:

EARLY SOCIAL DEVELOPMENT –

Relationship to siblings and peers:

____ individual play ____ group play
____ competitive ____ cooperative
____ leadership role ____ a follower

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

Educational History:

Name of School	City/State	Dates Attended: From	To	Grades completed at this school
Preschool				
Elementary				
Junior High				
High School				

Type of classes: ___ regular ___ learning disability
___ continuation ___ opportunity
___ emotionally handicapped ___ other

Did child skip a grade? ___ Yes ___ No Repeat a grade? ___ Yes ___ No
(If yes, please explain in detail.)

_____

Did child have any specific learning difficulties? ___ Yes ___ No

Has child ever had a tutor or other special help with schoolwork? ___ Yes ___ No

Does child attend school on a regular basis? ___ Yes ___ No

Does child appear motivated for school? ___ Yes ___ No

Has child ever been suspended or expelled? ___ Yes ___ No

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
(explain)

In school, how many friends does child have? ___ a lot ___ a few ___ none

What are child's educational aspirations? ___ quit school
___ graduate from high school
___ go to college

Has child had special testing in school? (If yes, what were the results?)

Psychological ___ Yes ___ No Vocational ___ Yes ___ No

List child's special interests, hobbies, skills:

_____

_____

_____

_____

Has the child ever had difficulty with the police? ___ Yes ___ No

(if yes, explain)

Has the child ever appeared in juvenile court? ___ Yes ___ No
(if yes, explain)

Has the child ever been on probation? ___ Yes ___ No

From To Reason Probation Officer

Has the child ever been employed? ___ Yes ___ No

Job Employer How long?

Additional comments(if any):

Therapist Date

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Child Checklist of Concerns

Name: _____ Date: _____

This checklist contains concerns (as well as positive traits) that apply mostly to children; therefore, mark any items that describe your child. Feel free to add any others at the end under "Any other characteristics."

__ Affectionate
__ Argues, "talks back," smart-alecky, defiant
__ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
__ Cheats
__ Cruel to animals
__ Concern for others
__ Conflicts with parents over persistent rule breaking, money, chores, homework, grades
__ Complains
__ Cries easily, feelings are easily hurt
__ Dawdles, procrastinates, wastes time
__ Difficulties with parent's paramour/new marriage/new family
__ Dependent, immature
__ Developmental delays
__ Disrupts family activities
__ Disobedient, uncooperative, refuses, noncompliant, doesn't follow rules
__ Distractible, inattentive, poor concentration, daydreams, slow to respond
__ Dropping out of school
__ Drug or alcohol use
__ Eating – poor manners, refuses, appetite increase or decrease, odd combinations, overeats
__ Exercise problems
__ Extracurricular activities interfere with academics
__ Failure in school
__ Fearful
__ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
__ Fire setting
__ Friendly, outgoing, social
__ Hypochondria, always complains of feeling sick
__ Immature, "clowns around," has only younger playmates
__ Imaginary playmates, fantasy
__ Independent
__ Interrupts, talks out, yells
__ Lacks organization, unprepared
__ Lacks respect for authority, insults, dares, provokes, manipulates
__ Learning disability
__ Legal difficulties – truancy, loitering, panhandling, drinking, vandalism, stealing, fights
__ Likes to be alone, withdraws, isolates
__ Lying
__ Low frustration tolerance, irritability
__ Mental retardation
__ Moody

__ Mute, refuses to speak
__ Nail biting
__ Nervous
__ Nightmares
__ Need for high degree of supervision at home over play/chores/schedule
__ Obedient
__ Obesity
__ Overactive, restless, hyperactive, overactive, out-of-seat behaviors, restlessness, noisy
__ Oppositional, resists, refuses, does not comply, negativism
__ Prejudiced, bigoted, insulting, name calling, intolerant
__ Pouts
__ Recent move, new school, loss of friends
__ Relationships with brothers/sisters or friends/peers are poor – competition, fights
__ Responsible
__ Rocking or other repetitive movements
__ Runs away
__ Sad, unhappy
__ Self-harming behaviors – biting or hitting self, head banging, scratching self
__ Speech difficulties
__ Sexual – sexual preoccupation, public masturbation, inappropriate sexual behaviors
__ Shy, timid
__ Stubborn
__ Suicide talk or attempt
__ Swearing, blasphemes, bathroom language, foul language
__ Temper tantrums, rages
__ Thumb sucking, finger sucking, hair chewing
__ Tics – involuntary rapid movements, noises, or word productions
__ Teased, picked on, victimized, bullied
__ Truant, school avoiding
__ Under active, slow moving or slow-responding, lethargic
__ Uncoordinated, accident-prone
__ Wetting or soiling the bed or clothes
__ Work problems, employment, work, alcoholism/overworking, can't keep a job

Any other characteristics:

_____

Look back over the concerns you have checked off and choose the one that you most want your child to be helped with. Which is it?

_____

This is a strictly confidential patient medical record. Law expressly prohibits Redisclosure or transfer.