



**PREMIER PSYCHOLOGICAL SERVICES**  
**CHILD/ADOLESCENT PSYCHOSOCIAL HISTORY**

**IDENTIFYING INFORMATION**

Date of Assessment: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Sex: (M) \_\_\_\_ (F) \_\_\_\_

Birth Date: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address (number and street): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

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 Premier Psychological Services to contact my child's pediatrician (name) \_\_\_\_\_ regarding treatment issues, symptoms, behaviors or other information necessary for the treatment of my child.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CHIEF COMPLAINT**

**Presenting Problems:** (check all that apply)

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 Withdrawn   | 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

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    M or F \_\_\_\_\_

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? \_\_\_\_\_

What are the sources of family income? \_\_\_\_\_

**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.

___ High fevers	AGE _____	___ Dental problems	AGE _____
___ 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: \_\_\_\_\_ Grades completed at  
From \_\_\_\_\_ To \_\_\_\_\_ 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?
-----	----------	-----------

---

---

---

