Alaska
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Child/Adolescent History Form

The Purpose of this questionnaire is to gather information about your child's history and present situation so that we may provide the most appropriate clinical services. Please answer each question as accurately as possible. No one will be allowed to see your child's records without your permission.

Child's Name _____ Date of Birth _____Sex: GIRL BOY

This form completed by: _____ Today's Date _____

Your relationship to the child: _____ With whom does this child reside? (Please circle one)
Natural Parents One Parent Alone Parent & Step-Parent Foster Parent
Foster/Adoptive Parents Legal Guardian Other (specify) _____

Home Address _____
STREET CITY STATE ZIP

Email: _____ Best contact Phone number: _____

Parents are (Circle one) Married Separated Divorced Widowed Unmarried

Child's Place of Birth: _____ Ethnicity _____

Is the child adopted? Y N Age at Adoption: _____ Handedness: Right Left Both

Mother's Information:
Name: _____ Date of Birth: _____ Contact with child? Y N
Occupation: _____ Highest grade completed in school: _____
Work Phone: _____ Home/Cell Phone: _____

Father's Information:
Name: _____ Date of Birth: _____ Contact with child? Y N
Occupation: _____ Highest grade completed in school: _____
Work Phone: _____ Home/Cell Phone: _____

Step-Parent's Information (If applicable)
Name: _____ Date of Birth: _____ Contact with child? Y N
Occupation: _____ Highest grade completed in school: _____
Work Phone: _____ Home/Cell Phone: _____

Moves since child's birth: _____

Other Children in the Family:

Name	Age	Sex	Grade	How is school going?

Other people in the household

Name	Age	Sex	Relationship to Patient
_____	_____	_____	_____
_____	_____	_____	_____

Area of Concern:

Provider or clinician (name) who referred your child for evaluation? _____

For what current problems or symptoms are you seeking help? _____

_____

_____

_____

How long has your child had these problems? _____

Have these problems become worse over time? Yes _____ No _____

Do both parents agree about the nature of your child's problems? Yes _____ No _____

What other types of treatment/evaluations has your child had? _____

_____

_____

_____

Has your child had any of the following? (check all that apply)

Neurological Exam ___ Spinal Tap __ CT Scan __ CT Scan ___ EEG __ X-rays ___ MRI ___

Evoked Potentials ___ Angiogram __ Myelogram ___ EMG ___ CT ___ Other _____

If yes, what were the results? _____

_____

_____

_____

Functional Changes (check all that apply)

Physical Functioning:

Weakness/Hemiplegia	___	Coordination	___	Fatigue	___
Headaches	___	Vision (R/L)	___	Hearing (R/L)	___
Pain	___	Appetite (Wt. Loss/Gain)	___	Sleep	___

Cognitive Functioning:

Orientation	___	Memory	___	Speech	___
Attention	___	Comprehension	___	Organization	___
Planning	___				

Personality/Interpersonal Relationship Changes:

Personality Change	___	Conduct/Behavior	___
Insight/Awareness	___	Affect/Mood	___

Current Functional Status:

Please rate the following as: (D) Dependent (A) Needing Assistance or (I) Independent:

Bathing:	___	Grooming (Hair/Teeth/Shave)	___
Walking (Gait/Balance)	___	Stairs (Number)	___
Eating (Swallowing)	___	Preparing Meals	___
Toileting	___	Incontinence (Bladder/Bowel)	___
Dressing	___	Other/Special Needs	_____

Medical History:

Has your child ever had any of the following general medical problems:

Ear Infections?	Yes	___	No	___
Slow Weight Gain?	Yes	___	No	___
Allergies?	Yes	___	No	___
Up-to-date Immunizations?	Yes	___	No	___

Please specify any surgeries your child has had: _____

_____

_____

Medications:

Please list all current prescribed medications and dosages: _____

_____

_____

Please list current over-the-counter medications your child is taking: _____

_____

_____

Please list any relevant previously prescribed medications: _____

_____

_____

Neurological History:

Has your child ever had any of the following neurological problems:

Head injury with loss of consciousness?	Yes	___	No	___	If yes, how long? _____
Head injury without loss of consciousness?	Yes	___	No	___	
Dazed, Confused, or Disoriented?	Yes	___	No	___	
Heat Exhaustion/Sunstroke?	Yes	___	No	___	
Partial Drowning?	Yes	___	No	___	
Exposure chemicals or fumes?	Yes	___	No	___	
Electrical or chemical shock?	Yes	___	No	___	
Fainting or dizzy spells?	Yes	___	No	___	
High fever over 103 degrees?	Yes	___	No	___	If yes, for how long? _____
Lead or other poisoning?	Yes	___	No	___	

Other: (specify) _____

Social Functioning:

Is your child involved in extracurricular/social activities: Yes ___ No ___

Please explain_____

What do you think of your child's friends? _____

_____

How well does your child form / maintain friendships /relationships with others?

Children own age: _____

Older Children: _____

Younger Children: _____

Opposite Sex: _____

School/Work: _____

Adults/Authority Figures: _____

Family: _____

Any anticipated changes in your child's support system? _____

_____

Family Medical History:

Condition	Child	Mother	Father	Sibling	Grandparent	Cousin
Hyperactive						
Behavior Problems						
Reading Difficulty						
Writing Difficulty						
Math Difficulty						
Speech Problems						
Slow Development						
Physical Deformities						
Depression						
Anxiety or Panic Attacks						
Bipolar Disorder						
Tic Disorder						
Alcohol Use						
Drug Abuse						
Overdose						
Intelectual Disability						
Cerebral Palsy						
Brain Hemorrhage						
Brain Tumor						
Encephalitis, Meningitis						
Convulsions, Seizures						
Severe Headaches						
Muscular Weakness						
Thyroid Disease						
Heart Disease						
Stroke						
Diabetes						
Anemia						
Rheumatic Fever						
Cancer						
Asthma						
GI Problems						
Early Deaths/Miscarriages						

Please specify any other relevant family medical history: _____
_____
_____
_____

Hearing:

Has your child ever been diagnosed with a hearing impairment? Yes ___ No ___

If yes, please specify: _____

Has your child been prescribed a hearing aid? Yes ___ No ___

If yes, does he/she wear it regularly? Yes ___ No ___

Vision:

When was your child's last eye exam? _____

What were the results of that exam? _____

Has your child been diagnosed with any visual impairment? Yes ___ No ___

If yes, please specify: _____

Sleep:

Please specify your child's typical sleep pattern (time to fall asleep, time to rise, amount of sleep per night):

_____

_____

Does your child have any of the following difficulties? (Check all that apply)

Falling asleep	___	Staying asleep	___	Snoring/snorting	___
Unpredictable length of sleep	___	Early riser	___	Very heavy sleeper	___
Nightmares	___	Night terrors	___	Sleep walking	___
Talking in sleep	___	Other: (specify)	_____		

Eating:

Does your child eat a healthy diet from all four food groups? Yes ___ No ___

Does your child have strange eating habits? Yes ___ No ___

Any recent change in your child's eating habits or appetite? Yes ___ No ___

If yes, please specify: _____

Any recent change in your child's weight? Yes ___ No ___

If yes, please specify gain or loss and how much over what period of time: _____

_____

_____

Substance Use:

Does your child smoke cigarettes? Yes ___ No ___

Does your child use alcohol? Yes ___ No ___

Does your child use illicit substances? Yes ___ No ___

Does your child abuse prescription meds? Yes ___ No ___

If yes, please specify: _____

Developmental History:

How many siblings does your child have? Biological ____ Adopted ____

Brothers ____ Sisters ____

What is your child's birth order? _____

Pregnancy: Uneventful ____ Complicated ____

Baby was born: Full term ____ Premature at ____ weeks' gestation

Delivery: Vaginal ____ Cesarean ____

Birth Weight (pounds and ounces: _____ Breast Fed: Yes ___ No ___

Age of Mother at Delivery: _____ Age of Father at Delivery: _____

About The Pregnancy:			**About the Newborn:**		
	Yes	**No**		**Yes**	**No**
Previous miscarriages			Twin pregnancy		
Previous premature babies			Trouble breathing		
Difficult pregnancy			Born with cord around neck		
Vomited often			Had to be resuscitated		
Bleeding first 3 months			Needed oxygen		
Bleeding second 3 months			Born with any defects		
Bleeding last 3 months			Had seizures		
Had an infection			Turned blue		
IWere you injured during pregnancy			Turned yellow (jaundice)		
Increased blood pressure			Jittery		
Gestational diabetes			Hypoglycemic		
Other illness(es)			Other illness		
Took medication (s)			Given medication (s) at birth		
Difficult delivery			In the hospital more than 3 days		
Labor was induced			In the hospital more than 7 days		
Labor more than 12 hours			Had trouble sucking to feed		
Labor less than 2 hours			Vomiting		
Caesarean section			Diarrhea		
Put to sleep for delivery			Skin problems		

If you answered yes to any of the above questions, please explain: _____

_____

_____

Developmental Milestones: When did your child?	**Age**	**On Time / Early / Late**
Sit up without help		
Walk alone		
Speak first words (not mama, dada)		
Put 2 words together		
Speak in 2 or 3 word sentences		
Use a spoon		
Begin to separate from parent easily		
Achieve complete DAY TIME dryness		
Achieve complete NIGHT TIME dryness		
Achieve complete bowel control		
Start to dress themself		
Catch a ball		
Begin to tie shoelaces		
Ride a 2 wheel bike		
Recognize Letters / Numbers		
Recite the alphabet		
Count to 20		
Read to themself		
Write his/her name		
Draw a stick figure		
Draw a person with a body		
Draw animals and scenes		

Current School: _____ Current Grade: _____

Placement: Regular ___ Special Ed. ___ (describe service): _____

Other Schools Attended:

Pre-School: _____
Kindergarten: _____
Grade School: _____
Jr High/Middle: _____
High School: _____

Overall, how does your child perform in school? Good ____ Fair ___ Poor ___ Grades/GPA: _____

What is your child's BEST class? _____ WORST class? _____

How does your child manage homework? _____

Has your child ever skipped a grade? Yes ___ No ___ When?_____
Has your child ever received an academic award? Yes ___ No ___ For what?_____
Have you ever been told your child is gifted? Yes ___ No ___ In what area?_____
Has your child repeated a grade? Yes ___ No ___ When?_____
Has your child ever had special education services? Yes ___ No ___ Explain_____
Has your child ever had to attend summer school? Yes ___ No ___ When?_____
Has your child ever had an individual IQ test? Yes ___ No ___ Why?_____
If yes, What was the reason, and results? _____
_____

How far do you expect your child to go in school? _____

Psychological History:

Has the child ever been treated as an inpatient for psychological/emotional problems? Yes___ No ___
Has the child ever been treated as an outpatient for psychological/emotional problems? Yes ___ No ___
Diagnoses: _____
Who treated the child: _____
What type of treatment: _____
Briefly describe any current psychological or emotional problems: _____
_____

Does your child have, or ever had problems such as:	**Yes**	**No**
Repetitive habits		
Rocking		
Head banging		
Thumb sucking		
Nervous twitches or tics		
Temper tantrums		
Self-destructive behavior		
Difficulty adhering to a schedule		
Unwillingness to go along with change in daily routine		
Shyness / bashfulness with strangers		
Lying, stealing, cheating		
Fire setting or cruelty to animals		
Trouble with the neighbors, teachers, or law enforcement		
Sadness		
Worry		

Fear of new people, places, or activities		
Fear of being alone		
Difficulty being consoled		
Little desire to be held		
Too much desire to be held		
Mind or body over activity		
Impulsivity		
Inattentiveness		
Extreme reaction to noise or sudden movement		
Sensory sensitivity		
Many complaints or headaches, stomachaches, or other medical concerns		

Is your child under any particular stress at this time? Yes ___ No ___

If yes, please specify: _____

_____

What are your child's particular strengths? _____

_____

What are your child's hobbies, interests, recreational / leisure activities?_____

_____

Any additional comments or concerns: _____

_____

_____