Northbrook Psychological Clinic, PLC

Child/Adolescent Personal History

(All information obtained in this form is confidential)

Child's Name: ____ Date: ____________________

Birth Date: __________________ Age: __________ Sex: M F

School: ____ Grade: ___________________________

Referred by: ______________________________ Address/Phone: ______________________________

Father's Name: ____ Age: ________________________

Occupation: ____

Mother's Name: ____ Age: ________________________

Occupation: ____

Sibling's Names, Ages, Grades: ____

Step Parent's Names, Ages, Occupations: ____

Developmental History Record

Please fill in any information you have on the areas listed below:

Pregnancy and Delivery (circle all that apply):

Type of Labor: Spontaneous, Induced

Type of Delivery: Normal, Breech, Other ____________________________

Fetal distress, forceps used, hemorrhage/blood loss, multiple births

Anesthesia Used: None, local anesthetic, general, muscle relaxant

Was child premature: Y or N

Birth weight: _________________________ Birth height: __________________________

Days in hospital following birth (child): _________________

Days in hospital following birth (mother): _______________

Did mother smoke during pregnancy? Y or N, if yes, number of cigarettes per day: _______________

Did mother drink alcohol during pregnancy? Y or N, if yes, what type and how much per day:

____

Did mother use any drugs (illegal or legal) during pregnancy? Y or N, if yes, what type and how much per day: ____

Did mother use any type of drugs PRIOR to pregnancy? Y or N, if yes, what type and how much per day:

____

Does mother currently use any type of drug/medication? Y or N, if yes, please specify: _______________

____

____

Prenatal medical illnesses and health care: ____

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Please circle any that applied to your child as an infant:

jaundice, incubator, blood transfusions, rashes, breathing problems, baby given oxygen, very quiet, very active, problems sucking, problems with eating/digestion, baby on heart monitor

Please list and explain any birth defects your child has: ____

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____

Any birth complications or problems? ____

____

Milestones:

Please write age that your child reached the following milestones:

Sit without support _____ Crawled _____ Toilet trained (day) _____

Walked w/o holding on _____ First steps _____ Toilet trained (night) _____

Dressed self with help _____ Ran ______ Dressed self alone _____

Does/did your child have wetting accidents? Y or N, if yes, how frequently? ________________________

Does/did your child have soiling accidents? Y or N, if yes, how frequently? _________________________

Overall, do you feel that your child developed at a slow, normal, or rapid rate? Please explain: ________

____

____

Speech and Language Development

Any speech, hearing, or language difficulties? Y or N, please explain: ______________________________

____

Health

Name of child's physician: ____

Address: ____

Phone: __________________________________

List all childhood illnesses, hospitalizations, medications, allergies, head trauma, significant accidents/ injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?
___Asthma	______	______________________________________
___Anemia	______	______________________________________
___Lead poisoning	______	______________________________________
___Meningitis	______	______________________________________

___Encephalitis _______ ____

___Seizures _______ ____

___Epilepsy _______ ____

___Hydrocephalus _______ ____

___Cerebral palsy _______ ____

___Mental retardation _______ ____

___Heart problem _______ ____

___Emotional problem _______ ____

___Vision difficulties _______ ____

___Hearing difficulties _______ ____

___Other: ____

Please list any medications (including how long been taking, dose, frequency): _______________________

____

____

Has your child received his/her immunizations? Y or N

Please list any surgeries/ hospitalizations (include age of child/ length of hospital stay): _______________

____

____

Has your child suffered from any type of head injury? Y or N, if yes please indicate child's age, how injury occurred, and if there was a loss of consciousness: ____

____

____

Has your child suffered from persistent ear infections? Y or N

Age at first ear infection: _________

Any medical treatment for ear infections (antibiotics, tubes, etc.): _______________________________

____

Homes where child and family have lived:

Date from:	Date to:	City/State:	Reason for Moving:	Any Problems?
_________	_________	_________________	_______________________	_____________
_________	_________	_________________	_______________________	_____________
_________	_________	_________________	_______________________	_____________
_________	_________	_________________	_______________________	_____________

Residential Placements, Institutional Placements, or Foster Care:

Date from:	Date to:	Program Name/Location:	Reason for Placement:
_________	_________	_______________________________	__________________________
_________	_________	_______________________________	__________________________
_________	_________	_______________________________	__________________________
_________	_________	_______________________________	__________________________

Personality as an Infant/Toddler

Below is a list of words that describe a child's personality and behavior. Please circle that describe your child.

happy, independent, prefers to be alone, follower, cheerful, quiet, even tempered, very active, friendly, disruptive, leader, affectionate, trouble sleeping, moody, hits others, sad, temper tantrums, trouble eating, fearful, inattentive, angry, sucks thumb, dependent, cries, often loud

Describe the above behaviors that you consider to problems for your child: _______________________

____

____

Has your child been diagnosed by a professional as having developmental delays and/or learning problems? Y or N, if yes, please explain: ____

____

Family History

Mother's Name: ______________________________ Education: __________________________________

Was mother in any type of special education classes? Y or N

What was mother's age at the time of pregnancy with this child? ______

Number of prior pregnancies: _________ Number of spontaneous abortions (miscarriages): __________

Did mother experience difficulties with any of the following?

Reading: Y or N If yes, please explain: ____

Writing: Y or N If yes, please explain: ____

Math: Y or N If yes, please explain: ____

Did mother repeat any grades? Y or N If yes, please specify: _____________________________________

Did mother have any behavioral problems? Y or N If yes, please specify: __________________________

____

Any psychiatric problems for which the mother has received treatment? Y or N If yes please describe the problems and the treatment received: ____

____

____

Father's Name: ______________________________ Education: __________________________________

Was father in any type of special education classes? Y or N

Did father experience difficulties with any of the following?

Reading: Y or N If yes, please explain: ____

Writing: Y or N If yes, please explain: ____

Math: Y or N If yes, please explain: ____

Did father repeat any grades? Y or N If yes, please specify: ____

Did father have any behavioral problems? Y or N If yes, please specify: ____________________________

____

Any psychiatric problems for which the father has received treatment? Y or N If yes please describe the problems and the treatment received: ____

____

____

Please list any unusual and/or traumatic family events in your child's life which you feel may have impacted upon his/her development and current functioning (birth of a sibling, death of a family member, divorce, etc.): ____

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This is strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

Parent Signature: ____ Date: ________________________

Parent Signature: ____ Date: ________________________

Reviewing Therapist

Signature/Credentials: ____ Date: ________________________