Rhonda L. Smith, PhD ~~ 520-331-1526 ~~ Child/Adolescent Form

Developmental, Social, and Health History

Instructions: Please complete this form as thoroughly as possible and to the best of your knowledge. The information you provide about your child that will help design a treatment plan that is specific to your child's needs. Please attach additional pages as needed to include more information.

Child's Legal Name:			
Child's Preferred Name (if different):			
Date of Birth:	Age:	Grade:	School & District:
Gender Child Identifies As: ☐ Male ☐ Female ☐ Other please specify:			
Primary Language of Child:		Primary Language of Home:	
Mother/Guardian's Name:		Father/Guardian's Name:	
Occupation:		Occupation:	
Phone:		Phone:	
Email:		Email:	

Reason for evaluation or primary concerns you have regarding your child's development. Also include your child's strengths, interests, and activities (e.g., sport teams, clubs).

_____

_____

_____

What do you hope to learn from this psychological/psycho-educational evaluation?

_____

_____

_____

FAMILY & HOME

1. Legal Guardian Status (check appropriate boxes):

☐ Biological Parents ☐ Adoptive Parents ☐ Step-Mother ☐ Group Home
☐ Biological Mother ☐ Adoptive Mother ☐ Step-Father ☐ Tribal Services
☐ Biological Father ☐ Adoptive Father ☐ Foster Parent ☐ Court
☐ Other (specify) _____

2. Marital Status of Parents (check one):

☐ Single ☐ Married ☐ Married, living apart ☐ Divorced (check custodial status)
☐ Married, separated ☐ Joint custody ☐ Sole custody - which parent? ___

3. Does child have visitation with non-custodial parent? ☐ Yes ☐ No If so, how often? _____

4. Persons living in the child's home: Please use the back of this page if additional space is needed (e.g., lives part-time with each parent, your child has step- or half-siblings).

Name	Age	Relationship to this Child	Occupation/Employer or School

5. Has your child lived with anyone other than with whom he/she is presently living? ☐ Yes ☐ No
If yes, please explain: _____

_____

6. List any significant people in your child's life who live outside the home: _____

_____

7. Check if your child has experienced any of the following events include approximate dates if known.

Event	Date	Event	Date
☐ Accident		☐ Homeless/share home	
☐ Sexual Abuse		☐ Parental problems	
☐ Emotional Abuse		☐ Move	
☐ Physical Abuse		☐ Parent job change	
☐ Birth of younger siblings		☐ Remarriage	
☐ Change of guardian		☐ Separations	
☐ Death of family member		☐ Sibling problem	
☐ Divorce		☐ Other:	

Please explain any of the items that you checked:

_____

_____

8. What individuals or agencies have been involved with your child?

Agency	Name/Location	Contact Person
☐ AzEIP		
☐ Child Protective Services		
☐ DDD		
☐ Head Start		
☐ Juvenile Detention Center		
☐ Mental/Behavioral Health		
☐ Other:		

DEVELOPMENTAL HISTORY

1. Describe any complications or other concerns during pregnancy (e.g., diabetes, high blood pressure, toxemia): _____

_____

2. Were drugs and/or alcohol used during pregnancy? ☐ Yes ☐ No If yes, please explain: _____

_____

3. Delivery:
☐ Full Term (38 weeks or later)
☐ Pre-Term ____ weeks gestation
☐ Labor Induced
Reason for induction: _____
☐ Forceps Used
☐ Vaginal
☐ C-Section
Reason for C-section: _____

4. Were there any problems before, during or immediately after birth? ☐ Yes ☐ No If yes, please explain: _____

_____

5. Birth Weight ____ pounds ____ ounce(s) 6. Length of hospital stay: Mother ____ day(s) Child:____ day(s)

7. Developmental Milestones

Milestone	Age	Milestone	Age	Milestone	Age
Sat alone		Spoke first words		Toilet trained	
Crawled		Put several words together		Stayed dry at night	
Walked alone		Spoke in complete sentences			

8. Describes your child's early temperament (e.g., e.g. sensitive, irritable, active, passive, happy, stubborn, etc.) _____

_____

MEDICAL INFORMATION

1. Does your child have any medical diagnoses (e.g., allergies, asthma), including birth defects or genetic disorders? ☐ Yes ☐ No If yes, please specify and list what your child is allergic to, also attach pertinent physician report or diagnostic statement: _____

_____

2. Has your child ever had a neurological, psychological, or psychiatric evaluation? ☐ Yes ☐ No
If yes, please bring a copy of the report and briefly describe results:_____

3. List any traumatic events not already noted and include age of child when it occurred: _____
_____

4. Date of Last Physical Examination: _____ Physician: _____
Has the physician been contacted regarding any of your current concerns? ☐ Yes ☐ No
If yes, what were the physician's findings? _____

5. Vision, Hearing, Sleep, Speech/Language

Has your child experienced problems with vision?	☐ No ☐ Yes Please explain:
Does your child have glasses or contacts? If yes, does he/she wear their glasses/contacts?	☐ No ☐ Yes Please specify:_____ ☐ No ☐ Yes
Has your child experienced problems with hearing?	☐ No ☐ Yes
Does your child sleep well? If no, please explain Bedtime: _____ Wakes up: _____	☐ No ☐ Yes Please explain:
Has your child experienced problems with speech?	☐ No ☐ Yes Please explain:

6. Please list any medications that your child is currently taking or has been prescribed within the past four years.

Medication	Dosage	Date(s) taken	Prescribing Physician	Reason(s) for medication	Adverse Effects

7. Has your child had any surgeries, serious illness, injury, head injury/concussion, or hospitalizations? If yes, please list.

Approximate Date(s)	Type of Event, Surgery, or Illness	Hospital, # of days, outcome

8. Is there a family history of ☐ medical diagnoses (e.g., diabetes, cancer, ADHD, hearing impairment), ☐ emotional difficulties (e.g., depression, anxiety), ☐abuse/domestic violence, ☐ alcohol/drug use, ☐ school dropout/failure, ☐ incarceration, ☐ gang affiliation, ☐ cognitive difficulties, ☐ speech/language difficulties, ☐ learning difficulties, ☐ or any other pertinent areas? ☐ No
If yes, please specify: _____

EDUCATIONAL HISTORY

1. Has your child ever been tested for special education? ☐ Yes ☐ No If yes, when? _____
Please bring a copy of the report.

2. Has your child ever been retained? ☐ Yes ☐ No If yes, what grade? _____

3. Check if your child has received any of the following services:

Service	Name/Location	Contact Person
☐ Speech/Language Therapy		
☐ Occupational Therapy		
☐ Physical Therapy		
☐ Counseling		
☐ Other:		

4. Do you have any difficulty getting your child to attend school? ☐ Yes ☐ No
If yes, please explain _____

5. Child's grades before this year have been: ☐ Low ☐ Average ☐ Above average
Child's grades this year have been: ☐ Low ☐ Average ☐ Above average

6. Do you feel that your child is experiencing problems in school? If so, what kind of problems? _____
_____

7. When were you first aware of the problem, and what do you think is causing it? _____
_____

8. Has your child mentioned problems with school? How does he/she feel about the problem? _____
_____

9. List subjects that are difficult for your child: _____
List subjects that are easy for your child: _____

BEHAVIOR AND SOCIAL/EMOTIONAL

1. Check if your child has experienced any of the following.

☐ Anger control problems	☐ Easily frustrated	☐ Physically fights with adults
☐ Anxiety	☐ Excessive fears	☐ Physically fights with peers
☐ Bedwetting	☐ Extreme mood swings	☐ Poor attention
☐ Cries easily	☐ Fidgets and squirms often	☐ Poor concentration
☐ Cruelty to animals	☐ Fights with siblings (physical, verbal)	☐ Risk-taking behaviors
☐ Depression	☐ Fire setting	☐ Self-harming behaviors
☐ Difficulty finishing tasks	☐ Impulsive	☐ Steals
☐ Difficulty following instructions	☐ Loses things often	☐ Talks excessively
☐ Dwells on one thought over and over	☐ Not easily calmed/comforted	☐ Throws tantrums
☐ Extreme mood swings	☐ Overactive and restless	☐ Tics
☐ Easily distracted	☐ Problems with peer relationships	☐ Other:

Please explain any other concerns not listed:
_____
_____

2. Do you consider your child to have a behavior or discipline problem? ☐ Yes ☐ No
If yes, has this increased recently? ☐ Yes ☐ No If yes, when? _____

3. Does your child have difficulties with the following:
Food (textures, smell, limited variety of foods) _____
Tactile (clothing tags, fabrics, socks, shoes, clothing in general) _____
Auditory (loud noise, public toilets, crowds) _____
Visual (bright noise, spinning objects) _____

4. Does your child have friends? ☐ Yes ☐ No If yes, are their friends ☐ Younger ☐ Near own age ☐ Older

5. Does your child have difficulty making friends? ☐ Yes ☐ No

6. How often does your child follow your instructions? ☐ Never ☐ Sometimes ☐ Most of the time ☐ Always