Center for

Academic and

Psychological

Services 

CHILD AND ADOLESCENT

PSYCHOSOCIAL HISTORY

QUESTIONNAIRE

Date **Your Name**

Demographic Information

Patient's Name
Date of Birth Age
School Grade

Family Structure

Mother Name DOB Father Name DOB
Married: Separated – Divorced - Widowed
No. Years Parents Married Current Marriage: Strained – Good – Excellent

Date Separated/Divorced
Date Remarried: Mother Father
Ex-spouse Relationship: Strained – Good – Excellent
Custody Arrangements: Mother Father
Visitation Arrangements: Frequency Consistency

Step-Mother Name Step-Father Name
Patient Relationship with Step-Mother: Strained – Good – Excellent
Patient Relationship with Step-Father: Strained – Good – Excellent

Sibling Name	DOB	Age	Grade	How Related	Quality of Relationship with Patient

Names of Household Members

Primary Language spoken at home

Presenting Problems: Briefly describe why you have sought evaluation at this time.

When did the difficulties begin?

What are your goals for this evaluation?

What solutions have been tried? What has been helpful or unhelpful?

Previous Evaluations: List any previous attempts at evaluation or intervention; please provide copies of any previous records or written reports pertinent to the presenting problems.

Date	Evaluator/Clinician	Results	Written Report Available

Developmental History

Was the patient adopted? If so, at what age was the patient at the time of adoption?
Describe any pertinent information regarding the adoption.

Pregnancy: Planned? Length of Pregnancy Prior or Subsequent Miscarriages

Delivery: Length of Labor Type of delivery Medications given during delivery

Birth Weight Apgar Score

Birth Condition:

Cord around neck
Breathing difficulty
Turned blue
Placed in an incubator
Other problems

Injured during birth
Required oxygen
Infection
Jaundiced

Describe specific information regarding any birth complications:

Early Life Problems: As an infant or toddler, did the patient have difficulties with

Appetite? Sucking Poor appetite Picky eater Extreme hunger Other

Sleep? Going or Staying asleep Heavy sleep Head banging Rocking
Night Terrors Sleepwalking Other

Body Control? Stiffness Looseness Uncoordinated Overactivity
Under active Made odd sounds, grunts, or snorts Twitch or jerk arms or head

Temperament? Hard to comfort or console Startled easily Cried often and easily
Desire to be held too often Trouble being satisfied Shy/Bashful Irritable
Temper Tantrums Self-destructive behavior Difficulty keeping to a schedule
Difficulty going along with change in daily schedule/routine

Other Medical Concerns? Colic Constipation Reflux Headache Stomachache

Developmental Milestones: At what age (in months) did the patient first

Sit up without help
Crawl
Walk alone
Speak first words
Put words together
Become fully bladder trained
Become fully bowel trained
Dress self
Separate from mother easily

Early Medical History:

Chicken Pox Measles Mumps Pneumonia Allergies Food Allergies

Asthma Ear Infections P.E. Tubes Strep Head Injury Loss of Consciousness

Seizures Meningitis Heart Problems Pregnancy Miscarriage

Sickle Cell Disease Tics/Vocalizations Diabetes Bladder/Bowel Problems

Genetic/Congenital Conditions (specify):

Other Medical conditions:

Describe relevant details to any medical conditions above, including age at onset and duration.

Note any major accidents, injuries, head trauma, loss of consciousness, surgeries/operations, or hospitalizations.

Family Medical History: Indicate if any parents, siblings, and paternal or maternal grandparents, aunts, or uncles have had any of the conditions listed below and who has had the condition.

Condition	Who	Condition	Who
Heart Problems		Cancer	
Diabetes		Kidney Trouble	
Thyroid Disease		Liver Disease	
Seizures		Asthma	
Drug Problem		Alcohol Problem	
Hyperactivity		Tourette Syndrome	
Depression		Learning Problems	
Nervous Breakdown		Anxiety	
Obsessive Compulsive Disorder		Schizophrenia	
Tics		Mental Retardation	
Bipolar Disorder		Other	

PsychoSocial History: Describe any significant changes, losses, moves, and other stresses that may have impacted the patient's development and/or functioning.

Current Development

Primary Care Provider/Pediatrician: Other Health Care Provider(s):

Date of last Physical Exam: Results:

Immunizations current?

Medication: Please list patient's medication used in the past.

Medication	Dosages	How long	Results

Please list any current medications used.

Medication	Dosages	How long	Results

Is the patient compliant with the medication?

List any medicines to which the patient is allergic.

Height Weight General Health

Activity Level: Under active – Normal – Over active

Motivation Level (High, Med., Low) for: Personal Interests School Homework

Household Chores Friends Family Activities

Sleep: Normal Going to sleep Staying asleep

Waking up in the morning Other problems

Temperament: Normal Laid back Irritable Moody Easily upset

Angry a lot Shy Worrier Anxious Outgoing

Relationships: Please briefly describe the quality of the patient's relationships with each family member and generally with teachers, authority figures, and peers.

School History

Note any problems the patient had starting to school.

Did the patient have any problems learning to read?
Has the patient been retained or repeated a grade? If so, which grade(s) and why?

Has the patient received any special services in the school setting?
If so, please explain and provide copies of relevant documentation from the school.

Provide a brief commentary on the patient's school history of performance, conduct, attitudes, and relationships with authority and peers:

Preschool

Elementary

Middle School

High School

Please note any specific concerns about the patient's current functioning in the school setting.

Substance Use History

Does the patient now use, or have a history of using tobacco products, alcohol, and/or drugs?

If yes, list which substances and how much:

Please note any other concerns and make any additional comments you believe may be relevant to this evaluation.