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**Child / Adolescent Psychosocial History**

**Identifying Information**

Name of client: \_\_\_\_\_ Sex: M / F  
Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_  
Present grade in school: \_\_\_\_\_ Name of school: \_\_\_\_\_  
Referral Source: \_\_\_\_\_  
Name of pediatrician/family practitioner: \_\_\_\_\_

**Chief Concern**

Presenting problems: (check all that apply):

- |  |  |                                     |                                     |   |
|--|--|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Very unhappy    | <input type="checkbox"/> Impulsive       | <input type="checkbox"/> Irritable  | <input type="checkbox"/> Stubborn   | <input type="checkbox"/> Temper outbursts |
| <input type="checkbox"/> Disobedient     | <input type="checkbox"/> Withdrawn       | <input type="checkbox"/> Infantile  | <input type="checkbox"/> Distracted | <input type="checkbox"/> Destructive      |
| <input type="checkbox"/> Fearful         | <input type="checkbox"/> Clumsy          | <input type="checkbox"/> Shy        | <input type="checkbox"/> Phobic     | <input type="checkbox"/> Mean to others   |
| <input type="checkbox"/> Disrespectful   | <input type="checkbox"/> Self-mutilating | <input type="checkbox"/> Overactive | <input type="checkbox"/> Truancy    | <input type="checkbox"/> Peer conflict    |
| <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Suicidal   | <input type="checkbox"/> Lying      | <input type="checkbox"/> Stealing         |
| <input type="checkbox"/> Anxious         | <input type="checkbox"/> School problems | <input type="checkbox"/> Lonely     | <input type="checkbox"/> Rocking    | <input type="checkbox"/> Social issues    |

How long have these problems occurred?  
\_\_\_\_\_

Have the problems changed at all over time (improved or worsened)? If so, how?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What happened that makes you seek help at this time?  
\_\_\_\_\_  
\_\_\_\_\_

Problems perceived to be:  very serious  serious  not serious

Does the child work with a psychotherapist for individual therapy? Yes / No  
If yes, please name the clinician: \_\_\_\_\_

Does the child have a clinical diagnosis? Yes / No  
If yes, please identify the current diagnosis: \_\_\_\_\_

**Psychosocial History**

**Current Family Situation:**

**Mother:**

Relationship to child      \_\_natural parent      \_\_step-parent  
   \_\_relative                      \_\_adoptive parent

Occupation \_\_\_\_\_  
Education \_\_\_\_\_ Religion \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Father:**

Relationship to child      \_\_natural parent      \_\_step-parent  
   \_\_relative                      \_\_adoptive parent

Occupation \_\_\_\_\_  
Education \_\_\_\_\_ Religion \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Marital History of Parents:**

Natural parents:      \_\_married      when \_\_\_\_\_      age \_\_\_\_\_  
   \_\_separated      when \_\_\_\_\_  
   \_\_divorced      when \_\_\_\_\_  
   \_\_deceased      M or F \_\_\_\_\_  
Step-parents:      \_\_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:**

Number of times family has moved in child's life: \_\_\_\_\_  
Age of child at time of each move: \_\_\_\_\_

Present home:      \_\_apartment      \_\_condo      \_\_house  
   \_\_rent              \_\_own  
Number of bedrooms: \_\_\_\_\_  
Who's in each room? \_\_\_\_\_

Has the child ever been separated from parents for longer than a week?

What are the major family stressors at this time?  
\_\_\_\_\_  
\_\_\_\_\_

**Brothers and Sisters:**

(indicate if step-brothers or step-sisters):

Name	Age	Sex	School/Occupation	Living at home?

Do any family members (immediate and extended family members) have a history of substance abuse, mental illness or legal problems? If so, please explain:

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**Health of Family Members:**

Does or did any member of the child's family have any problems with  
\_\_\_reading? \_\_\_math? \_\_\_speech? \_\_\_spelling?

If yes, please explain:

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Is there any history in the child's family of  
\_\_\_mental retardation? \_\_\_epilepsy? \_\_\_birth defects? \_\_\_schizophrenia?

If yes, please explain:

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**Child Health Information:**

Has the child ever been hospitalized? \_\_\_yes \_\_\_no

If yes, please explain:

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Has the child ever taken, or is he/she taking presently any prescribed medications?

\_\_\_yes \_\_\_no

Name of medication	Dosage of medication	Reason for medication	Length of time on medication	Prescribed by:

**Developmental History:**

Length of pregnancy: \_\_\_\_\_

Was mother under the care of a physician? \_\_\_\_\_

If mother was ill or upset during pregnancy, please explain:

\_\_\_\_\_

Birth weight: \_\_\_\_\_ lbs      \_\_\_\_\_ oz

If premature, how early? \_\_\_\_\_      If overdue, how late? \_\_\_\_\_

Type of delivery: \_\_\_\_\_

Physical condition of infant at birth: \_\_\_\_\_

Did mother abuse alcohol/drugs during pregnancy?    \_\_\_yes      \_\_\_\_\_no

Newborn period:

Irritability                      \_\_\_yes \_\_\_no    duration: \_\_\_\_\_

Vomiting                        \_\_\_yes \_\_\_no    duration: \_\_\_\_\_

Difficulty breathing        \_\_\_yes \_\_\_no    duration: \_\_\_\_\_

Difficulty sleeping         \_\_\_yes \_\_\_no    duration: \_\_\_\_\_

Convulsions                    \_\_\_yes \_\_\_no    duration: \_\_\_\_\_

Colic                              \_\_\_yes \_\_\_no    duration: \_\_\_\_\_

Normal weight gain?        \_\_\_yes \_\_\_no

Was child breast fed?        \_\_\_yes \_\_\_no    If yes, how long? \_\_\_\_\_

Developmental milestones:

Age at which child:

Sat up                             \_\_\_\_\_

Crawled                         \_\_\_\_\_

Walked                          \_\_\_\_\_

Spoke single words         \_\_\_\_\_

Spoke sentences             \_\_\_\_\_

Bladder trained              \_\_\_\_\_

Bowel trained                \_\_\_\_\_

Rode a tricycle               \_\_\_\_\_

Tied shoes                      \_\_\_\_\_

Early Social Development:

Did the child attend nursery school/daycare?    \_\_\_yes \_\_\_no

If yes, where and at what age?

\_\_\_\_\_

Relationship of child to sibling and peers:

\_\_\_individual play      \_\_\_group play              \_\_\_competitive

\_\_\_cooperative          \_\_\_a leader                  \_\_\_a follower

Describe special habits, fears, or idiosyncrasies of the child at this age:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Educational History:

	Name of school	City/State	Dates attended	Grades completed
Preschool				
Elementary school				
Junior High				
High School				

Types of classes: \_\_\_regular education \_\_\_special education

Does the child have an IEP under IDEA? \_\_\_yes \_\_\_no

If yes, please explain or provide a copy of the IEP:

\_\_\_\_\_

\_\_\_\_\_

Does the child have a 504 plan? \_\_\_yes \_\_\_no

If yes, please explain or provide a copy of the documentation:

\_\_\_\_\_

\_\_\_\_\_

Has the child ever repeated a grade? \_\_\_yes \_\_\_no If so, which grade? \_\_\_\_\_

Has the child ever skipped a grade? \_\_\_yes \_\_\_no If so, which grade? \_\_\_\_\_

Does the child have any specific learning differences? \_\_\_yes \_\_\_no

If yes, please explain: \_\_\_\_\_

Academic performance:

Highest grade on last report card? \_\_\_\_\_ Lowest grade on last report card? \_\_\_\_\_

Favorite subject in school: \_\_\_\_\_

Least favorite subject in school: \_\_\_\_\_

Describe participation in any extracurricular activities:

\_\_\_\_\_

In school, how many friends does child have? \_\_\_\_\_

Has the child had any special testing in school? \_\_\_yes \_\_\_no

If yes, please summarize the results:

\_\_\_\_\_

\_\_\_\_\_

List the child's special interests, hobbies or skills:

\_\_\_\_\_

Has the child ever been in any legal trouble? \_\_\_yes \_\_\_no

If yes, please explain: \_\_\_\_\_

Name of parent completing history: \_\_\_\_\_

Signature of parent: \_\_\_\_\_ Date \_\_\_\_\_