

THE PSYCHOLOGICAL TRAUMA CENTER

a division of Preventive Psychiatry Associates Medical Group, Inc.

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CHILD/ADOLESCENT HISTORY

Today's Date: ___/___/___ Person completing this questionnaire: _____

NAME			
ADDRESS			
CITY	STATE	ZIP	PHONE

CHILD'S NAME		DATE OF BIRTH	
ADDRESS			
CITY	STATE	ZIP	PHONE

The following information would help us to help the child. Careful attention to the questions and completeness in answering will contribute to the thoroughness with which the child will be understood.

Who are the primary caregivers at the child's address (please check the appropriate choices)

- | | |
|--|--|
| <input type="checkbox"/> Biological Mother | <input type="checkbox"/> Biological Father |
| <input type="checkbox"/> Stepmother | <input type="checkbox"/> Stepfather |
| <input type="checkbox"/> Adoptive Mother | <input type="checkbox"/> Adoptive Father |
| <input type="checkbox"/> Foster Mother | <input type="checkbox"/> Foster Father |

Legal Guardian: _____

Relative (please specify): _____

Please give the following information about the caregivers checked above

Name	Date of Birth	Occupation
Name	Date of Birth	Occupation

If the caregivers are not the biological parents, please answer the following questions about the biological parents:

NAME OF BIOLOGICAL MOTHER	DATE OF BIRTH	ADDRESS
NAME OF BIOLOGICAL FATHER	DATE OF BIRTH	ADDRESS

Is the caregiver family's combined income over \$45,000 per year? Yes No

Is the caregiver family's combined income under \$45,000 per year? Yes No

Please list other persons living in the child's household presently:

NAME	SEX	DATE OF BIRTH	RELATIONSHIP TO CHILD

Please check any of the following which have occurred or any presently happening in the child's family

- | | |
|---|---|
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Marital Separation |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Long Absence |
| <input type="checkbox"/> Serious Physical Illness | <input type="checkbox"/> Death |
| <input type="checkbox"/> Placement in Foster Care | <input type="checkbox"/> Other important event(s) not mentioned |

Please give a brief account of any of the above family events that have occurred:

Has anyone in the biological family received psychiatric help? Yes No

If so, please describe the problem:

Family Member	Problem	Date

Please describe any problems or situations for which help is presently sought

Family Member	Problem

INFORMATION ABOUT THE CHILD

Describe <u>past</u> emotional problems or related difficulties of the child

What about him/her do you find easy?

What about him/her do you find difficult?

What about him/her do you find puzzling?

What about him/her do you find enjoyable?

Is he/she quiet or talkative?

Does he/she prefer to give take directions?

Do you, he or she follow routines such as washing, mealtime or bedtime? Yes No

Are the routines important to him/her or would he/she prefer to ignore them?

Does he/she have a favorite toy or object? Yes No

What type of discipline works best for him/her?

THE CHILD'S PLAY

What does he/she like to do when alone?

What toys or equipment does he/she enjoy?

What stories or dramatic games does he/she play?

Does he/she have any questions or special garments he/she prefers? Yes No

If yes, please list: _____

SOCIALLY

With whom does he/she play?

Name	Sex	Age	Relationship

How does he/she get along with brothers, sisters or familiar playmates?

Does he/she have a preference for adult or child companionship?

How does he/she react to new children or adults?

How do they react to the child?

REACTIONS TO SPECIFIC EXPERIENCES

Please list dates and places of any preschool or school experiences and reactions

Place	Group	Date	Reaction

Please describe any emotions or reactions you noticed regarding:

Experience	Date	Reaction
Going to school at the beginning	/ /	
Leaving home or parents	/ /	
Being away from home by him/herself	/ /	
Being away from home with his/her parents	/ /	
Close family member goes away on business trip	/ /	
Close family member is hospitalized	/ /	
Other separations (please specify)	/ /	

Does he/she have a pet?..... Yes No

What is it? _____

How does he/she feel about it? _____

Has he/she ever lost a pet? Yes No

How did he/she react to losing the pet? _____

Has he/she ever moved from one home to another? <input type="checkbox"/> Yes <input type="checkbox"/> No	
From where?	To where?
Date of the move	What was his/her reaction?

I F HE/SHE WAS ADOPTED:
What was his/her age?
What does he/she know about the facts?
What was his/her first reaction to learning that he/she was adopted?
What are his/her current attitude about being adopted?

HEALTH

Has he/she ever been seriously ill? Yes No

If yes, what was wrong? _____

Has he/she been hospitalized? Yes No

If yes, what was the reason for the hospitalization? _____

Date of hospitalization ____/____/____.

Did anyone stay with him/her? Yes No

Who stayed with him/her? _____

What was his/her reaction to the hospitalization or illness? _____

DEVELOPMENT

How do you feel his/her development is coming along with regard to the following:

- | | | | |
|-----------------|--|----------------------------------|--|
| Development | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Physical Growth | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Speech | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Vocabulary | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Coordination | <input type="checkbox"/> Above Average | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |

Please make any other comments you feel are important regarding his/her development:

Please check if he/she is presently experiencing any of the following. Please comment where necessary.

	Problem	Comment
	Night terrors	
	Bed wetting	
	Fears	
	Thumb sucking	
	Finicky about food	
	Tantrums	
	Easily frustrated	
	Nail biting	
	Eating non-foods	
	Problem	Comment
	Easily fatigued	
	Frequent body complaints	
	Rituals	
	Speech difficulties	
	Frequent digestive disturbances	
	Other difficulties (specify)	

If he/she is under nine years of age:

How much of dressing can he/she do alone?
How much of washing can he/she do alone?
Does he/she usually do these things alone?

EATING:

How was he/she fed milk as an infant?
Age when off breast milk
Age when off bottle milk
Age began using cup
Age began solids:
How is his/her appetite
Foods preferred
Foods disliked
Does he/she enjoy eating alone? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does he/she enjoy eating with other children or adults? <input type="checkbox"/> Yes <input type="checkbox"/> No

SLEEPING

Does he/she have a special bedtime routine? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what is it?
When does he/she go to sleep
When does he/she wake up?
Does he/she waken at night? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does he/she get out of bed in the night? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does he/she have nightmares? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does he/she sleepwalk? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does he/she nap? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does he/she share a room with anyone? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, with whom?

