Rivertowns
Center for Attention
ONE BRIDGE STREET, SUITE 24/IRVINGTON, NY 10533/ P. 914.231.6563/ F. 914.591.4225

CHILD & ADOLESCENT HISTORY FORM

Having you carefully fill in this form prior to our first meeting will help reduce the time involved in gathering this information at our office. Please answer all questions as well as you can.

The following is considered confidential and privileged information.

Child's Name: ________________________________Date of Birth:_____________ Age:__________

Name of person completing this form: ____

Relationship to the child: ____________________________________ Date: ____________________

Mother's name: ____ Age: _____________________

Education: _________________________ Occupation: ____

Home telephone: ____________________________Work telephone: ______________________ _____

Mobile telephone:____________________________ e mail address:______________________________

Home Address: ____

Father's name: ____ Age: _____________________

Education: _________________________ Occupation: ____

Home telephone: ____________________________Work telephone: __________________________

Mobile telephone:____________________________ e mail address: ___________________________

Home Address: ____

Parents are biological___ adoptive___ foster___/ married___ divorced__ separated___

Sibling Names	Age	Sex	Education	Living with child?

Others living in the home: ____

REFERRAL INFORMATION

Person who referred you to Rivertowns Center for Attention:____________________________

What are the main problems or concerns that prompted the referral? ____________________

At what age were these difficulties first noted? By whom? ____________________

Is your child currently receiving psychotherapy for the above listed problem(s)? Is yes, please list the name and contact information of the provider. ____________________

Is your child currently taking medication(s) for the above listed problem(s)? If yes, please provide the name and contact information of the prescribing physician and list the medication(s), including the dosage.

What specific **question(s)** do you have that you hope an evaluation will answer?

My child's strengths are: ____________________

My child's weaknesses are: ____________________

MENTAL HEALTH TREATMENT HISTORY

Has your child ever received an evaluation, testing, or treatment with a psychologist, psychiatrist, or other mental health practitioner for this or other problems? If yes, please list the names and contact information of the professionals from whom he/she has received services.
Please bring copies of previous test results/reports to the first appointment.

Dates	Purpose	Professional	Telephone Number

Has your child ever taken medication in the **past** for this or any other mental health problems?

Drug Name/Dose	Prescribed by	Date(s)	Results

CHILD'S MEDICAL HISTORY

Name of Pediatrician: ______________________

Telephone Number: ______________________

Office Address: ______________________

____

Date of last physical Examination: ______________________

Does your child have a history of medical problems (i.e., head injury, seizures, allergies, asthma, frequent ear infections)?

____

____

____

List any hospitalizations and surgeries.

____

____

____

Does your child see any medical specialists? If yes, please list reason, area of specialty, name, and contact information of physician.

____
____
____

Does your child have a history of hearing problems? If yes, then please explain:

____
____
____

Does your child have a history of vision problems? If yes, then please explain:

____
____
____

Date of last vision examination? ____

Please list name and contact information of eye doctor. ______________________________

____
____

CHILD'S DEVELOPMENTAL HISTORY

Pregnancy

Age of mother at delivery: _______

Describe any known health problems of mother during pregnancy:

____
____

Birth History

Birth Weight ______________ Birth was vaginal or cesarean ________________

Baby was full term ______ Premature ______ (Weeks gestation __________)

Describe any difficulties during delivery: ____

____

Describe any medical problems noted at birth or during infancy: ________________________

____

Developmental Milestones

Please give age at which the child did the following. If you do not remember the exact age, then please give an approximate age:

Motor

Age: sat alone _________ stood alone _______ walked alone _______

Handedness right ___ left ___both ___

Any history of occupational or physical therapy? If yes, then please explain:

____
____
____

Language

Age spoke first word _____ Age put 2-3 words together ______ Other languages spoken at home ______

Any history of speech/language therapy? If yes, then please explain:

____
____
____

Do you consider your child to understand directions and situations as well as other children his/her age? If not, then please explain:

____
____
____

Toileting

Age when trained of urine ______ Age when trained of stool ______

Any problems with bedwetting or accidents/soiling? If yes, then please explain:

____
____
____

Early Temperament Was your child:

Easily comforted ______ Colicky ______ Restless ______ Friendly ______

Into everything ______ Moody ______ A good sleeper ______

CURRENT SOCIAL BEHAVIOR/ ABILITY TO RELATE TO OTHERS

Please describe your child's relationships and interactions with the following people:

Adults/Authority figures: ____

____

____

____

Siblings: ____

____

____

____

Peers: ____

____

____

____

Does your child get along better with children: Older ___ Younger____ Same age? _____

At what age level do you believe your child is functioning socially? ____________________

Does your child have and keep friends? If no, then please explain:

____

____

____

Have best friend? __________________________ Group of friends? ________________

Activities with friends (include frequency, duration, and problems): ___________________________

____

____

____

____

____

____

____

____

EDUCATIONAL HISTORY

Current school name: ______________________________ District: _______________

Address: ____

Telephone: ____

Current Grade: ____ Any grades repeated? _______ Any grades skipped? _______________

Has your child ever been evaluated at school? _____ If yes, please list the type of evaluation and the date completed. **Please bring copies of previous test results/reports to the first appointment.**

Does you child receive any educational services? Special Education _____ 504 Plan _____ Other______

If your child is receiving Special Education services, please indicate Special Education Classification:

Other Health Impaired ______ Learning Disabled ______

Speech Impaired_____ Emotionally Disturbed ______ Visually Impaired ______

Other (specify)____

If your child is receiving Special Education or educational services under a 504 Plan, please circle types of services being received:

Occupational Therapy | Resource Room | Speech/Language Therapy

Physical Therapy | SEIT/Push-In Instruction | Adaptive Phys. Ed

Counseling | Collaborative Class (CTT) | Self-Contained Class

Other (specify)____

If your child is receiving educational accommodations and/or modifications specified in an IEP or 504 Plan, please list:

____

____

____

If your child has worked with a private tutor, please list.

Date	Subject Area	Name of Tutor	Telephone Number

Do teachers report any current school problems? If yes, then please explain:

____
____
____
____
____
____

Names of contact persons in school (e.g., teacher, guidance counselor, psychologist)

Name	Position	Telephone Number	email address

FAMILY HISTORY

Family history can often be helpful in understanding a child's problems.

Please check any box that applies:

Has anyone in the family had:	*Siblings*	*Parents*	*Extended Family*
Motor problems			
Reading problems			
Speech/language problems			
School/learning problems			
Autism/ Autistic spectrum disorders			
Mental Retardation			
Alcohol/drug problems			
Anxiety			
Depression			
Bipolar Disorder			
Suicide/ suicide attempts			
Other psychological disorders			
Seizures/epilepsy			
Attention problems/hyperactivity			

Do any family members have problems similar to your child's reason for referral? Please explain.

____
____

Do any medical illnesses run in your family (i.e., seizures, thyroid problems, allergies)? If yes, please explain.

____
____

ADDITIONAL INFORMATION:

Please include other information that you believe will be of help in understanding your child. Include any questions you would like me to answer. Feel free to add additional paper if necessary.