Centers for Family Change: CHILD/ADOLESCENT INFORMATION FORM

Child's Name ____
Date of Birth _________________   Age ____________   Gender ______________
Pediatrician ____
Pediatrician's Address ____
Phone _________________________   Fax# _________________________

DEVELOPMENTAL HISTORY

(Check all that apply)

Problems during mother's pregnancy:

_____ None
_____ kidney infection
_____ emotional stress
_____ alcohol use
_____ cigarette use
_____ high blood pressure
_____ German measles
_____ bleeding
_____ drug use
_____ other

____

Birth: _____ normal delivery
_____ Cesarean delivery
_____ difficulty delivery
_____ Complications

____

Infancy: _______ feeding problems
_______ sleep problems
_______ toilet training problems

Developmental Milestones: (mark "N" for normal, "E" for early and "D" for delayed)

_____ sitting
_____ standing
_____ walking
_____ talking
_____ potty training
_____ playing with peers

MEDICAL HISTORY

(Check all that apply)

_____ allergies
_____ ear infections
_____ asthma
_____ autism
_____ pneumonia
_____ scarlet fever
_____ measles
_____ mumps
_____ whooping cough

_____ significant injuries (describe) ____
____
_____ chronic, serious health problems (describe)________________________________

Prescribed Medications: Yes___ No___ Please list:

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Does the patient smoke cigarettes? Yes/No
Has the patient used alcohol? Yes/No
Current use: ____
Has the patient used recreational drugs? Yes/No
Current use:____
Has the patient ever been hospitalized for psychiatric reasons? Yes/No
Dates of hospitalization: ____
Has the patient ever been in outpatient psychotherapy? Yes/No If yes, when ______________
Who was the therapist? ____

FAMILY AND SCHOOL HISTORY

Biological Parents' marital status:

_____ single, never married
_____ separated for _____ years
_____ divorce in process for _____ months
_____ married for _____ years
_____ divorced for _____ years
_____ mother deceased for _____ years
_____ father deceased for _____ years

How many siblings does the patient have? ________ Ages _____________________
How many step/half-siblings does the patient have? _____ Ages_________________

If parents are re- married, please complete the following statements:

_____ Mother is currently remarried to __________________________
What year were they married? _________________
Any additional marriages? Yes/no How many? _________

_____ Father is currently remarried to ___________________________
What year were they married? _________________
Any additional marriages? Yes/No How many? _________

_____ Mother is living with someone. They have lived together for _________ years.
_____ Father is living with someone. They have lived together for _________ years.

Name of current school: ____
School phone: ___________________________ Current grade: ______________
Name of teacher:__________________________________
Does your child have an IEP or 504 plan? Yes/ No
What year did it start? ________________

Parent completing form: ____

Signature of Parent Completing form: _______________________________Date: _______