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Licensed Psychologist

Child/Adolescent History Form

Date:_____

Child's Name:_____ Age:_____ DOB:_____
School:_____ Grade:_____

Parents:	Name	Age	Education	Occupation
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Stepmother	_____	_____	_____	_____
Stepfather	_____	_____	_____	_____

Marital Status: Married_____ Separated____ Widowed____ Other_____
Date married_____ Date Separated/Divorced_____ Date remarried_____

Other Family Members:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who is the child's pediatrician?_____
Current medical/physical problems:_____
_____

Is your child being treated by a psychiatrist? If so, who?_____

Please list any medications that your child is taking:	Dosage:	What for:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child report or do you notice any side effects?_____
_____

What are your primary concerns about your child?

Is your child aware of the problems and/or concerns? Is your child worried?

What questions would you like to have answered?

Describe your goals for treatment with your child:

Has anything happened that may have caused and/or contributed to the emotional/behavioral problems that your child is experiencing?

Are there any legal issues currently affecting your child (e.g. divorce, custody, criminal activities, etc.)?

Signature:
Relationship to child: