A specialty clinic at HRA PSYCHOLOGICAL SERVICES

CHILD/ADOLESCENT HISTORY FORM

Patient Name: ____ Preferred Name: ________________________________

Patient Date of Birth: ___________________________ Age: ___________ Race: ____________________________

Sex assigned at birth: ________________ Gender: _____________ Pronouns: ________________________

Handedness: ☐ Right ☐ Left ☐ Unspecified Primary Language(s): ☐ English ☐ Spanish ☐ Other: ________________

Is the patient: ☐ biological ☐ adopted ☐ foster ☐ other: ____

WHAT ARE THE PRESENTING CONCERNS / REASON FOR ASSESSMENT?

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____

PRENATAL / BIRTH HISTORY

Biological mother's age at time of patient's birth: ____________ Adequate Prenatal Care? ☐ Yes ☐ No ☐ Unknown

Complications during pregnancy? (e.g., substance use, maternal stress/trauma, physical injury) ☐ No

☐ Yes, please describe: ____

____

____

____

Delivery method: ☐ Vaginal ☐ Cesarean ☐ Emergency C-section Birth Weight: ____________

Delivery time: ☐ Full term ☐ Premature, born at _______ weeks or months

Complications with labor or delivery (e.g., NICU care)? ☐ No ☐ Yes, please describe below

____

____

____

____

DEVELOPMENTAL MILESTONES

Language: ☐ On target ☐ Advanced ☐ Delayed Received Speech/Language therapy? Yes No

Motor: ☐ On target ☐ Advanced ☐ Delayed Received Physical/Occupational therapy? PT OT None

Toileting: ☐ On target ☐ Advanced ☐ Delayed Current: Daytime wetting/soiling Nighttime wetting/soiling

Other: ____

____

____

MEDICAL HISTORY

Immunizations: ☐ Current / On-time ☐ Current / Adjusted Schedule ☐ Delayed

Current medical diagnoses: (common conditions include asthma, allergies, eczema, diabetes) ☐ None

____

____

Past medical diagnoses: ☐ None

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____

Surgeries/Hospitalizations: ☐ None

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____

Genetic Conditions/Congenital issues: ☐ None

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____

Concussion/Head Injury: ☐ None

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Seizures: ☐ None

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Appetite / Eating concerns: ☐ None

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Hearing or Vision concerns: ☐ None

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Sleep concerns: ☐ None

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____

Sensory processing concerns: ☐ None

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____

Other Medical? ☐ None

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____

NEURODEVELOPMENTAL / PSYCHOLOGICAL HISTORY

Current diagnoses: (ADHD, Autism, Anxiety, Depression, etc.) ☐ None

____

____

Intervention History

Psychiatric Hospitalization(s): ☐ None ☐ Yes, Dates or ages: ____

Partial Program/Hospitalization(s): ☐ None ☐ Yes, Dates or ages: ____

Testing/Evaluation(s): ☐ None ☐ Yes, Dates/Location: ____

Findings/results: ____

Therapy: ☐ None ☐ Current, Therapist name: ____

☐ Past, Therapist name(s), approx. dates: ____

Medication: ☐ None ☐ Current: ____

Past medications: ____

Prescribing physician, physician's assistant, nurse practitioner name: ___________________________________

FAMILY

Current living situation: ☐ Biological parent(s) ☐ Foster parent(s) ☐ Adoptive parent(s) ☐ Guardian(s)

Other: ____

If separate households, custody arrangement: ____

People living in the home(s) & relationship to patient:

____

____

____

Diagnoses of parents and/or siblings: ____

Diagnoses in extended family: ☐ None in maternal ☐ Unknown in maternal ☐ None in paternal ☐ Unknown in paternal

Maternal: ____________________________________ Paternal: ____________________________________

History of losses, changes, or traumas: ☐ None

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____

____

STRENGTHS / SOCIAL / LEISURE

Patient's attributes/strengths:

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____

Hobbies/Sports/Participation in activities:

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____

Interests:

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____

Social skills: ☐ Concerns ☐ No concerns

Is patient interested in friends? ☐ Yes ☐ No, has the patient ever been interested in friends? ☐ Yes ☐ No

Please briefly share about the patient's social interactions:

____

____

LEGAL

Is there any history of legal involvement (court dealings, charges, need to call/involve authorities for any reason): ☐ No

☐ Yes: ____

____

EDUCATION

Current School: ____ Current grade: __________

Schooling Type: ☐ In-person ☐ Homeschool ☐ Virtual Program ☐ Hybrid ☐ Other: _______________

Past schools attended: ____

____

Did patient participate in any preschool or developmental program prior to kindergarten? ☐ Yes ☐ No

Has patient ever been retained/held back? ☐ Yes ☐ No

Has patient ever been suspended or expelled? ☐ Yes ☐ No

If yes to any, please explain:

____

Does the patient have an Individualized Education Plan (IEP)? ☐ Yes currently ☐ Not currently ☐ Never

If yes, what is/was the eligibility criteria (e.g., OHI, SLD, SLI, ASD, EI, CI; usually on first page of IEP):

____

Does the patient have a Section 504 plan? ☐ Yes currently ☐ Not currently ☐ Never

Describe the patient's academic performance and classroom behavior:

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OTHER INFORMATION

This document is to collect vital information in preparation for the parent interview. There may be greater detail or additional information that you would like to share and this will be discussed in-depth. You are welcome to provide additional documents during or before the visit. To make the most of the parent interview, please bring copies of (or send ahead of time) important documents such as previous evaluations, IEPs, medical records, etc.

Is there anything we did not ask about that you want to share on this form?

Please visit our website for additional information that you may find useful to help prepare for the parent interview and the rest of the assessment process. https://hrapsychservices.com/pmc