Educating Youth Services, 200 North Main Street, South Bldg., Unit #3, East Longmeadow, MA 01028

CHILD AND ADOLESCENT SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Child's full name _____ DOB_____ Age_____

Grade_____ Classroom teacher _____

Current Address: _____

How long at this address? _____

Person providing information: _____

Relationship to child_____

Name if Insured: _____ DOB: _____

Insurance Company: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Amount of Deductible Owed: _____ Co-insurance Payment Amount: _____

Who does child live with: □ both parents □ mother □ father □ other (specify) _____

Biological father_____ Occupation_____ Years education: _____

Father's home phone_____ Work #_____ Cell #_____

Biological mother_____ Occupation_____ Years education: _____

Mother's home phone _____ Work #_____ Cell #_____

If applicable: Guardian's name_____ Occupation _____Years education_____

Guardian's home phone _____ Work #_____Cell # _____

Please list all people in child's immediate family:_____

_____

Name Relationship to child Age / Grade Living in house?_____

_____

Please list all other *non-family* members who live in household:_____

_____

Name Relationship to child/family How long has lived in household?_____

_____

Language(s) spoken at home _____

Primary Language at home_____

Please list all locations (city, state) that your child has lived (use back of page, if needed):

1. Birthplace _____ Moved at age_____grade_____

2. _____ Moved at age_____grade_____

3. _____ Moved at age_____grade_____

Are biological parents of child currently: □ married □ separated □divorced □ never married

• If separated or divorced, who has *legal* custody? □ mother □ father □ other (specify): _____

_____

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce?_____

_____

Are there other adults who have a ***significant*** part in raising your child? □Yes □No

If so, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.)_____

_____

Have there been any significant changes in the home over the *last few years*? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc)_____

_____

What do you feel are your child's…

Strengths_____

Weaknesses _____

Briefly describe your concerns for your child._____

_____

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is your child: □ biological child □ adopted child □ foster child □ other: _____

Mother's age at birth? _____ Did mother receive routine medical prenatal care? □Yes □ No

Please specify any medications used during pregnancy and the reason used: _____

_____

Pregnancy lasted _____weeks / months Child's birth weight: _____pounds _____ounces

APGAR score …at 1 minute_____ …at 5 minutes_____ □ Unsure / Don't know

Did child go home from the hospital at the same time as the mother? □Yes □ No If No, explain why:_____

_____

Please check the conditions below that describe the health of the child and mother during…

Mothers pregnancy

- ☐ No complications
- ☐ Blackouts
- ☐ Falls
- ☐ Physical injury
- ☐ Excessive bleeding
- ☐ Hypertension
- ☐ Diabetes
- ☐ Emotional stress
- ☐ Toxemia
- ☐ Alcohol and/or drug use
- ☐ Use of tobacco

Child's Delivery

- ☐ Normal
- ☐ Induced labor
- ☐ C-section
- ☐ Breech birth
- ☐ Unusually long labor (>12 hours)
- ☐ Premature # of weeks
- ☐ Overdue # of weeks _____
- ☐ Other problem (specify)

_____

Child's Condition at Birth

- ☐ Normal
- ☐ Lack of oxygen
- ☐ Breathing problem
- ☐ Birth injury/defect
- ☐ Jaundice
- ☐ Newborn ICU # of days
- ☐ Other problem (specify)

_____

B. Health

Describe the state of your child's current health: □ Excellent □ Good □ Fair □ Poor

Is your child currently taking any medication? □Yes □ No

If yes, please list medications and uses: _____

_____

Has your child ever been identified as having a disability? □Yes □ No

If so, by whom, what age, & what disability? _____

_____

Has your child ever received psychological counseling? □Yes □ No

If so, by whom (professional/agency) and when: _____

_____

Has your child ever participated in therapy services from a private entity? (i.e., speech, occupational, physical, vision therapy, etc)? □Yes □ No

If so, by whom (professional/agency) and when: _____

_____

Has your child ever participated in educational services from a private entity (i.e., private tutor, Sylvan Learning Center)? □Yes □ No

If so, by whom (professional/agency) and when: _____

_____

Has your child ever participated in an early intervention program? □Yes □ No

If so, by whom (professional/agency) and when: _____

_____

Has your child had any of the following? Please check all that apply.	**Please describe and give details, dates, and/or age of onset**
☐ Serious Illnesses	
☐ Head Injuries	
☐ Seizures or convulsions	
☐ Surgery/Hospitalization	
☐ History of Ear Infections	
☐ Allergies and/or Asthma	
☐ Vision Problems	
☐ Hearing Problems	
☐ Frequent Nightmares and/or Bedwetting	
☐ Other health problem	

Family History

Is there a *family history* of the following problems?	*Biological* family member with the history… (parent, sister/brother, aunt/uncle, grandparent, 1st cousin, etc.)
☐ Learning Difficulties (reading, math, writing, spelling)	
☐ Speech or Language problem (articulation, stuttering, etc.)	
☐ Developmental Disorder (such as Autism, Asperger's disorder, etc.)	
☐ Emotional Problems (depression, excessive anxiety, mood swings, etc.)	
☐ Intellectual Disability	
☐ School Failure (failing grades, dropout, etc)	
☐ Drug or Alcohol Addiction	

C. Development

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat up without help								
Crawled								
Walked alone								
Walked up Stairs								
Spoke first words								
Spoke short phrases								
Spoke in sentences								
Fully bladder trained								
Fully bowel trained								
Stayed dry all night								

III. BEHAVIOR

A. Behavior in Infancy

During your child's first *few years of life*, were any of the following present to *significant* degree?

- ☐ Did not enjoy cuddling
- ☐ Was not easily calmed by being held or being stroked
- ☐ Difficult to comfort
- ☐ Colicky
- ☐ Excessive irritability
- ☐ Diminished sleep
- ☐ Frequent head banging
- ☐ Difficult nursing
- ☐ Poor eye contact
- ☐ Did not turn towards caregivers
- ☐ Did not respond to name
- ☐ Did not respond to speech of caregivers
- ☐ Fascination with certain objects
- ☐ Constantly into everything

* Please describe all checked items

_____

_____

B. Child's Early Temperament: (*Toddler through five years of age*)

☐ Activity Level – How active has your child been from an early age? _____

_____

☐ Distractibility – How well was your child able to maintain focus or concentration, or pay attention to tasks? _____

_____

_____

☐ Adaptability - How well was your child able to deal with transition, change, or when denied his/her own way? _____

_____

_____

☐ Approach/Withdrawal – How well was your child able to respond to new things (i.e., new places, people, food, etc.)? _____

_____

_____

☐ Intensity – Whether happy/unhappy, how strong were your child's feelings exhibited? Were others made aware of when your child was upset, angry, disappointed, etc.? _____

_____

☐ Mood – What was your child's basic mood? Did he/she exhibit frequent or rapid changes in mood or temperament? _____

_____

_____

☐ Regularity – How predictable was your child's patterns of activity level, sleep, appetite, etc.? _____

_____

Prior to age six, did your child have more difficulty than other children his/her age…

- ☐ Sitting still at meal time
- ☐ Paying attention when read to
- ☐ Throwing a ball
- ☐ Catching a ball
- ☐ Buttoning and zipping
- ☐ Holding a crayon or pencil
- ☐ Accidentally dropping things
- ☐ Staying focused on TV, movies, or video games
- ☐ Waiting for a turn to play
- ☐ Knowing left and right
- ☐ Acting without thinking
- ☐ Dressing self
- ☐ Tying shoe laces
- ☐ Accidentally knocking things over

C. Differential Behaviors

Please check below all behaviors or characteristics that fit your child over the past year:

- ☐ Fidgets, is easily distracted, has a hard time staying seated, has difficulty waiting for his/her turn
- ☐ Talks excessively, interrupts often, doesn't listen
- ☐ Low energy/fatigue
- ☐ Poor concentration
- ☐ Difficulty initiating tasks
- ☐ Difficulty completing tasks
- ☐ Difficulty following instructions
- ☐ Engages in impulsive behaviors (acts before thinking)
- ☐ Immature compared to peers
- ☐ Engages in physically dangerous activities
- ☐ Often argumentative with adults
- ☐ Often actively defiant to adult requests and rules
- ☐ Blames others for own mistakes
- ☐ Often angry or resentful
- ☐ Somatic complaints of not feeling well
- ☐ Excessive separation difficulties
- ☐ Easily frustrated
- ☐ Lies
- ☐ Steals
- ☐ Aggressive towards others
  - o Adults
  - o Peers
- ☐ Often depressed/irritable mood
- ☐ Often loses things, very disorganized compared to others his/her age.
- ☐ Shy
- ☐ Feeling of worthlessness or low self-esteem
- ☐ Withdrawn
- ☐ Overly anxious or fearful
- ☐ Sleeping too little/insomnia
- ☐ Sleeping to much
- ☐ Difficulty making decisions
- ☐ Cries easily
- ☐ Temper tantrums
- ☐ Rapid mood changes/mood swings
- ☐ Suicidal thoughts
- ☐ Excessive need for reassurance
- ☐ Poor appetite
- ☐ Overeats
- ☐ Explosive temper with minimal provocation
- ☐ Odd fascinations
- ☐ Unrealistic worry about futures events
- ☐ Substance abuse
  - o Drug
  - o Alcohol
  - o other

Please explain all checked items: _____

_____

_____

_____

_____

D. Home Behavior:

How often is each of the following settings a *problem* for your child?

While getting ready for school	☐ Rarely	☐ Sometimes	☐ Frequently
When eating at the dinner table	☐ Rarely	☐ Sometimes	☐ Frequently
When playing by him/herself	☐ Rarely	☐ Sometimes	☐ Frequently
When playing with siblings/other children	☐ Rarely	☐ Sometimes	☐ Frequently
When with a babysitter or daycare	☐ Rarely	☐ Sometimes	☐ Frequently
In public places (church, store)	☐ Rarely	☐ Sometimes	☐ Frequently

When in the car	□ Rarely	□ Sometimes	□ Frequently
When told to do something he/she doesn't want to do	□ Rarely	□ Sometimes	□ Frequently
During sit-down homework time	□ Rarely	□ Sometimes	□ Frequently
When watching TV or playing video games	□ Rarely	□ Sometimes	□ Frequently

How would you describe your child's personality at home?_____

_____

How does your child get along with brothers/sisters? _____

Which adult would your child prefer to talk with about a problem? _____

Who is the *family member* with whom your child feels closest? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior problems at home? (spanking, talking, positive reinforcement, time-out, grounding, etc.)_____

_____

How does your child respond to discipline?_____

List any responsibilities your child has at home: _____

Does your child do these regularly? __Yes __ No

Does your child need frequent reminders? __Yes __No

Indicate child's… Bed time? ____:____PM Wake time? ____:____ AM Does child sleep well? __Yes __ No

How much time does your child typically spend on electronic media? _____

Watching T V: _____hrs/day; Playing video/computer games: _____hrs/day; Other:_____ hrs/day

Have any family members expressed concerns about your child's behavior? __Yes __ No

Explain:_____

_____

E. Social Behavior:

How would you describe your child's peer relationships and choice of friends? (i.e. How many friends? What age/genders? Is child shy, outgoing, a leader, a follower, etc? Does child associate w/ scholars or troublemakers?) _____

_____

_____

How does your child interact with children in the neighborhood?_____

_____

IV. Educational History

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____

How much of a struggle is homework? □ Not a struggle □ Sometimes a struggle □ Often struggles

Does your child receive special school services (IEP, 504 plan, Gifted/Talented)? □ Yes □ No

If yes, what services, when did they begin?_____

Below, please list schools attended and describe your child's academic and/or behavioral performance:

Preschool/Daycare_____

_____

Elementary

School_____

_____

Middle

School_____

_____

High

School_____

_____

----------DO NOT COMPLETE BELOW THIS LINE----------

V. Suicide Risk

Have you ever thought about hurting yourself? Yes No Have you ever cut / hurt yourself deliberately? Yes No

_____

Have you ever thought of suicide? Yes No _____

Have you ever attempted suicide? Yes No _____

_____

Thinking about it currently? Yes No Plan: _____ Means: _____ Intent: _____

Access to a weapon? Yes No _____

Has anyone in your family or a close friend ever attempted or committed suicide? Yes No _____

_____

_____

VI. Homicide Risk:

Have you ever thought of hurting or threatened or attempted to hurt others? Yes No _____

_____

Have you ever actually physically hurt anyone? Yes No _____

_____

VII. Psychosis - current or history

Hallucinations

___ Yes ___ No Auditory _____

___ Yes ___ No Visual _____

___ Yes ___ No Tactile _____

___ Yes ___ No Olfactory _____

Delusions

___ Yes ___ No Delusions of persecution or paranoia _____

___ Yes ___ No Delusions of reference _____

___ Yes ___ No Delusions of grandeur_____

___ Yes ___ No Delusions of control_____

Comments: _____

_____

VIII. Mental Status Exam

- Appearance: WNL · unkempt · poor hygiene · tense · rigid
- Behavior/Motor Disturbances: WNL · agitated · guarded · tremor · manic · impulsive · psychomotor retardation · tearful · easily startled · distracted · hysterical · restless
- Orientation: WNL · Disoriented to: time · place · person · situation
- Speech: WNL · pressured · slowed · soft · loud · slurred · incoherent
- Mood: WNL · depressed · angry · hostile · euphoric · anxious · anhedonic · withdrawn
- Range of Affect: WNL · constricted · blunted · flat · labile · inappropriate
- Thought Content: WNL · impaired · unfocused · unreasonable · preoccupation · delusions · thought insertion · grandiose · ideas of reference · paranoid · obsessions · phobias
- Thought Process: WNL · illogical · abstract · concrete · incoherent · perseverative · impaired concentration · loose associations · flight of ideas · circumstantial · blocking · tangential
- Sensory: WNL · illusions · flashbacks · hallucinations: auditory · visual · olfactory · tactile
- Memory: WNL · Impaired: recent · remote · immediate
- Appetite: WNL · increased · decreased Weight: stable · loss · gain
- Sleep: WNL · hypersomnia · onset problem · maintenance problem
- Insight: WNL · blaming · little · none
- Judgment: WNL · impaired · poor
- Estimated Intellectual Functioning: above average · average · below average · diagnosed intellectually deficient · unable to determine

IX. Mental Status Summary:

_____

_____

_____

X. Diagnosis:

_____

_____

XI. Recommendations:

This client may benefit from behavioral outpatient therapy to address:

_____

_____

Counselor Signature with Credentials: _____ Date / Time completed: _____