

**Centers for Family Change: CHILD/ADOLESCENT INFORMATION FORM**

Child's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_  
Pediatrician \_\_\_\_\_  
Pediatrician's Address \_\_\_\_\_  
Phone \_\_\_\_\_ Fax# \_\_\_\_\_

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**DEVELOPMENTAL HISTORY**

(Check all that apply)

**Problems during mother's pregnancy:**

- |   |  |
|---|--|
| <input type="checkbox"/> None             | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> kidney infection | <input type="checkbox"/> German measles      |
| <input type="checkbox"/> emotional stress | <input type="checkbox"/> bleeding            |
| <input type="checkbox"/> alcohol use      | <input type="checkbox"/> drug use            |
| <input type="checkbox"/> cigarette use    | <input type="checkbox"/> other               |

**Birth:**  normal delivery  difficulty delivery  
 Cesarean delivery  Complications

**Infancy:**  feeding problems  
 sleep problems  
 toilet training problems

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

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> sitting  | <input type="checkbox"/> talking            |
| <input type="checkbox"/> standing | <input type="checkbox"/> potty training     |
| <input type="checkbox"/> walking  | <input type="checkbox"/> playing with peers |

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**MEDICAL HISTORY**

(Check all that apply)

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> ear infections | <input type="checkbox"/> asthma         |
| <input type="checkbox"/> autism    | <input type="checkbox"/> pneumonia      | <input type="checkbox"/> scarlet fever  |
| <input type="checkbox"/> measles   | <input type="checkbox"/> mumps          | <input type="checkbox"/> 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? \_\_\_\_\_

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**FAMILY AND SCHOOL HISTORY**

Biological Parents' marital status:

\_\_\_\_\_ single, never married

\_\_\_\_\_ married for \_\_\_\_\_ years

\_\_\_\_\_ separated for \_\_\_\_\_ years

\_\_\_\_\_ divorced for \_\_\_\_\_ years

\_\_\_\_\_ divorce in process for

\_\_\_\_\_ mother deceased for \_\_\_\_\_ years

\_\_\_\_\_ months

\_\_\_\_\_ 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: \_\_\_\_\_