

Child Developmental History Record

Today's date: _____

Client Name: _____ Birth Date: _____

Name of parent/legal guardian: _____

CHILD/ADOLESCENT INTAKE FORM

PRESENTING PROBLEMS AND CONCERNS

Please describe the problem that brought you here today:

Please check all your child's behaviors and symptoms that you consider problematic:

- | | | | |
|---|-----------------------|----------------------|--------------------------------|
| Distractibility | Homicidal thoughts | Fire setting | Wide mood swings |
| Change in appetite | Suicidal thoughts | Thoughts of death | Swearing |
| Visual hallucinations | Sleep problems | Obsessive thoughts | Computer addiction |
| Manipulative behavior | Poor memory/confusion | Stealing | Low self-worth |
| Hyperactivity | Fear away from home | Work/school problems | Suspicion/paranoia |
| Withdrawal from people | Frequent arguments | Self-harm behaviors | Curfew violations |
| Defiance | Nightmares | Compulsive behavior | Loneliness |
| No/few friends | Sadness/depression | Destroys property | Fatigue |
| Impulsivity | Social discomfort | Legal problems | Hearing voices |
| Anxiety/worry | Irritability/anger | Crying spells | Lying |
| Aggression/fights | Toileting problems | Racing thoughts | Lack of motivation |
| Eating problems | Hopelessness | Running away | Recurring, disturbing memories |
| Boredom | Phobias | Sexual behavior | |
| Panic attacks | Peer/sibling conflict | Alcohol/Drug Use | |
| Alcohol/Drug Use (please list substance, and use history below) | | | |

How long with problematic symptoms/behaviors? (check one)

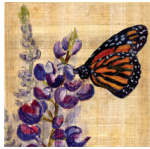
___ Less than 1 month ___ 1- 6 mos ___ 6 -11 mos ___ 1-2 yrs ___ 3-5 yrs ___ 6 + yrs

Are your child's problems affecting any of the following?

- | | | |
|-------------------------|-------------|-------------------------|
| Handling everyday tasks | Self-esteem | Relationships |
| Hygiene | Health | Recreational activities |
| Work/School | Housing | Legal matters |
| Finances | | |

Has your child ever had thoughts, made statements, or attempted to hurt him/herself? ___ No ___ Yes

If yes, please describe:



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Has your child ever had thoughts, made statements, or attempted to hurt someone else? ___No ___ Yes If yes, please describe: _____

Has your child recently been physically hurt or threatened by someone else? ___No ___ Yes If yes, please describe: _____

Has your child gambled in the past 6 months? ___No ___ Yes If yes, let us know the following: ___No ___ Yes
 Has your child ever felt the need to bet more and more money? ___No ___ Yes Has your child ever had to lie to people about how much your child has gambled?

FAMILY AND DEVELOPMENTAL HISTORY

- | | |
|-------------------------------|---------------|
| Family Mental Health Problems | Family Member |
| ADHD | |
| Sexually Abused | |
| Depression | |
| Manic Depression | |
| Suicide | |
| Anxiety | |
| Panic Attacks | |
| Obsessive-Compulsive | |
| Anger/Abusive | |
| Schizophrenia | |
| Eating Disorder | |
| Alcohol Abuse/Drug Abuse | |

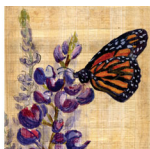
Were there any medical problems during the pregnancy or birth of your child? ___No ___ Yes
 If yes, please describe: _____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? ___No ___ Yes If yes, please describes substances used, quantity, and frequency: _____

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? ___No ___ Yes If yes, please describe: _____

PREVIOUS MENTAL HEALTH TREATMENT

	Type of Treatment	Dates	Provider	Reason for Treatment
	Outpatient Counseling			
	Psychiatric Hospitalization			
	Drug/Alcohol Treatment			
	Medication (mental health)			



SCHOOL INFORMATION

Current grade/placement: _____

This year's school *grades*: ___ Excellent ___ Good ___ Fair ___ Poor

Past school *grades*: ___ Excellent ___ Good ___ Fair ___ Poor

This year's school *behavior*: ___ Excellent ___ Good ___ Fair ___ Poor

Past school *behavior*: ___ Excellent ___ Good ___ Fair ___ Poor

Has your child had any of the following difficulties at school?

_____ Suspension _____ Incomplete homework _____ Learning problems _____ Referrals or detentions

_____ Poor grades _____ Teased or picked on _____ Speech problems _____ Attendance problems

_____ Gang influence

Does your child have an after-school provider? ___ No ___ Yes If so, who? _____

Has your child ever repeated or skipped a grade? ___ No ___ Yes If yes, which one(s)? _____

Has your child ever received Special Education services or have an IEP? ___ No ___ Yes

If yes, please describe: _____

Health

List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition	Age	Treated by whom?	Consequences?

Residences

1. Homes

Dates: From	To	Location	With whom	Reason for moving	Any problems?

2. Residential placements, institutional placements, or foster care

Dates		Program name or location	Reason for placement	Problems?
From	to			

Special skills or talents of child

List hobbies, sports; recreational, musical, TV, and toy preferences; etc.:

Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important? If the child is adopted or in foster care, please include dates of adoption, number of foster placements etc.) *(If more room is needed please use the other side of this page).*
