Child and Adolescent History and Goals

Please complete this questionnaire. This information helps your child's clinician gain an understanding of the problems for which you are requesting our assistance. The form is designed for both children and adolescents, so some questions may not apply to your child.

Child's Full Name _____ Date _____

DOB _____ Age _____ Person completing form _____

Relationship to the child _____

Contact Information

Relationship	Name	Phone	Email
Mother			
Father			
Legal Guardian			
Child lives with			

Reason for Visit

List problems that resulted in the referral _____

Approximately how long the problems have been noticed? _____

Please explain any concerns you have about your child's safety _____

Treatment History By Mental Health Professionals

Date	Name of Professional	Treatment	Response

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Child's Development

MOTHER'S PREGNANCY

How many months was the pregnancy? _____

During Pregnancy	No	Yes	Explain
Was there any use of prescribed drugs by the mother?	☐	☐	
Were there any significant medical problems or major parental stressors?	☐	☐	
Was there any use of cigarettes by the mother?	☐	☐	
Was there any use of alcohol / illegal drugs by the mother?	☐	☐	

LABOR & DELIVERY

Delivery ☐ Pre-term ☐ Full-term ☐ Vaginal ☐ C-Section

Birth weight _____ lbs. _____ oz

Describe any complications _____

Did the child experience any early medical problems (sucking, breathing, jaundice, etc.)

DEVELOPMENT

Accomplishment	Early	Normal Range	Delayed	Explain any loss of previously mastered skills
Sit without support of parent	☐	4-6 months	☐	
Walking	☐	12-16 months	☐	
Speech (single words)	☐	15-18 months	☐	

TEMPERMENT DURING THE PRESCHOOL YEARS

Behavior	Yes	No	Explain
Fearful	☐	☐	
Shy	☐	☐	
Aggressive	☐	☐	
Hyperactive	☐	☐	
Passive	☐	☐	

Describe any other behavioral problems noticed during the preschool years. _____

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Medical History

Primary Care Physician _____ Specialists _____

Please describe any serious or longstanding illnesses the child has experience(_____

Does your child experience chronic pain? ☐ Yes ☐ No

If yes, explain. _____

Has the child experienced head injury, seizures, loss of consciousness? ☐ Yes ☐ No

If yes, explain. _____

List any surgeries the child has had and the approximate dates

Date	Surgery

Is there any history of medical problems that run in the family (for instance, diabetes, heart disease, etc.)

IF child is FEMALE, has menstruation begun? ☐ Yes ☐ No

At what time does the child awaken in the morning? _____ What time is bedtime _____

Does the child appear well rested? _____

X	Substances child has used	Age first used	Current amount used
☐	Cigarettes / other forms of nicotine		
☐	Alcohol		
☐	Marijuana		
☐	Cocaine		
☐	Methamphetamines		
☐	Other:		

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Child's Full Name _____ Date _____

Child's Education

School Name _____ Phone _____

Address, City, State, Zip _____

School Counselor _____ Homeroom Teacher _____

Grade _____ Does your child have an IEP? ☐ Yes ☐ No

Reason for IEP? _____

Has the child ever been retained or held back a grade? ☐ Yes ☐ No Grade retained? _____

Reason retained? _____

Explain any special education or gifted services the child has received. _____

Describe overall adjustment to daycare / preschool _____

Describe overall adjustment / performance in Kindergarten _____

Describe overall adjustment / performance in first grad _____

What kind of grades does the child usually receive? _____

Grades this year have ☐ Worsened ☐ Improved

Has the child experienced any of the following	Yes	No	If yes, explain
Refusal to attend school	☐	☐	
School phobia	☐	☐	
Truancy	☐	☐	
Suspension from school	☐	☐	
Expulsion from school	☐	☐	

Discuss any other school concerns _____

*****Please provide copies of all report cards, standardized tests and any testing which may have been completed in an academic or counseling setting.*****

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Peer Relationships / Friendships

Approximately how many friends does the child have? _____

Does the child have a best friend? ☐ Yes ☐ No For how long? _____

Has the child demonstrated any of the following	Yes	No	Describe other peer problems
Fight / argue frequently with peers	☐	☐	
Have difficulty making friends	☐	☐	
Have difficulty keeping friends	☐	☐	
Tend to associate with older children	☐	☐	
Tend to associate with younger children	☐	☐	
Tend to associate with children who get into trouble	☐	☐	
Prefer to play with children of the opposite sex	☐	☐	
Get teased by other children	☐	☐	
Is the child a bully	☐	☐	
Do you approve of the child's friends	☐	☐	
Is the adolescent dating	☐	☐	
Is the adolescent sexually active	☐	☐	

Activities

List any organization / organized group activities which the child participates (e.g. church, sports, scouts, etc.)

Is spirituality a significant part of your child's life? ☐ Yes ☐ No

Does your child participate in a spiritual community? ☐ Yes ☐ No

What religion or denomination does your child identify with? ☐ Yes ☐ No

List any unorganized activities in which the child participates (video, games, skateboarding, e

Approximately how many hours of television does the child watch per week? _____

Approximately how many hours of homework does the child complete per night? _____

Does the child usually complete homework if assigned? ☐ Yes ☐ No

How does the child obtain allowance? _____

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IN49 HX - CHILD / ADOL

Child's Full Name _____ Date _____

Family Data

LIST OF PARENTAL FIGURES

Relationship	Name	Age	Education	In the home Yes	In the home No	Profession
Mother	☐ Birth ☐ Adoptive			☐	☐	
Father	☐ Birth ☐ Adoptive			☐	☐	
Stepmothers				☐	☐	
				☐	☐	
Stepfathers				☐	☐	
				☐	☐	
Other-Specify				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

Is the child adopted? ☐ Yes ☐ No At what age? _____

Where was the child before adoption? _____

When were birth/adopting parents married? _____ Separated? ☐ Divorced? ☐

If separated or divorced, what was the child's reaction? _____

What is the visitation / custody arrangement? _____

Who has legal custody? _____

Is there any anticipation or possible change of custody at this time? ☐ Yes ☐ No

How cooperative are the divorced parents in making decisions / arrangement _____

How does the child relate to step parents and/or boyfriends / girlfriends, if applicable _____

LIST OF SIBLINGS

Name	Age	Relationship (brother, sister, full, half, step, adopted)	Get along? Yes	Get along? No	Behavioral or Emotional Problem
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

Describe any sibling-related issues you think are important

_____

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Child's Full Name _____ Date _____

Family Data (Continued…)

Indicate with any "X" any of the following experienced by the child or nay biological relatives

Difficulty	This Child	Father	Mother	Grandparent	Sister	Brother
Agoraphobia / panic attacks	☐	☐	☐	☐	☐	☐
Alcohol / Substance Abuse	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Antisocial behavior / arrests / incarceration	☐	☐	☐	☐	☐	☐
Attention Deficit / Hyperactivity Disorder	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐	☐	☐
Loss/death of significant person	☐	☐	☐	☐	☐	☐
Manic depression / Bipolar Disorder	☐	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
Tourette's Disease / Tics	☐	☐	☐	☐	☐	☐
Victim of Physical Abuse	☐	☐	☐	☐	☐	☐
Victim of Emotional Abuse	☐	☐	☐	☐	☐	☐
Victim of Sexual abuse	☐	☐	☐	☐	☐	☐

Strengths

What in your opinion are the strengths and assets? _____

Goals & Expectations

What type of services are you interested in receiving from Mind Rejuvenation to help your child overcome the problems that bring you to treatment?

☐ Assessment & Consultation ☐ Medication ☐ Individual psychotherapy
☐ Family therapy ☐ Group therapy with children / adolescents who have similar problems
☐ Specify other: _____

What do you want to be different in the child's life and relationships as a result of receiving treatment? _____

How will the child be behaving, thinking and feeling when the problem no longer interferes with his / her life? _____

Pediatric Symptom Checklist-17 (PSC-17)

Child's Full Name _____ Date _____

Caregiver completing this form _____

Please mark under the heading that best fits your child.

Symptom	Never	Sometimes	Often	*Office Use Only* I	A	E
Fidgety, unable to sit still	☐	☐	☐			
Feels sad, unhappy	☐	☐	☐			
Daydreams too much	☐	☐	☐			
Refuses to share	☐	☐	☐			
Does not understand other people's feelings	☐	☐	☐			
Feels hopeless	☐	☐	☐			
Has trouble concentrating	☐	☐	☐			
Fights with other children	☐	☐	☐			
Is down on him / herself	☐	☐	☐			
Blames others for his / her troubles	☐	☐	☐			
Seem to be having less fun	☐	☐	☐			
Does not listen to rules	☐	☐	☐			
Act as if driven by a motor	☐	☐	☐			
Teases others	☐	☐	☐			
Worries a lot	☐	☐	☐			
Takes things that do not belong to him or her	☐	☐	☐			
Distracted easily	☐	☐	☐			
Scoring Totals						

Scoring

* **Fill in unshaded box on right with:**
  - Never = 0
  - Sometimes = 1
  - Often = 2

* **Sum the columns**
  - Column I = PSC-17 Internalizing
  - Column A = PSC-17 Attention
  - Column E = PSC-17 Externalizing

PSC Total Score is sum of I, A & E columns

Suggested Screen Cutoff:

PSC-17 - I	≥	5
PSC-17 - A	≥	7
PSC-17 - E	≥	7
Total Score	≥	**15**

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.