Oakland Psychological Clinic, P.C.

CHILD/ADOLESCENT CONFIDENTIAL HISTORY

TO BE COMPLETED BY THE PARENT/GUARDIAN

Patient Name: ______________________________ Date of Birth: ______________________

Adopted: [ ] Natural: [ ] Place of Birth: ______________________

Where Was the Child/Adolescent Raised? ______________________

Current Height: ____________ Current Weight: ____________

FAMILY

	Name	Date of Birth	City/State of Residence	Lives with Minor? (Yes or No- Approx. Yr)	If deceased, date, age, and cause of death
Biological Mother:					
Biological Father:					
Step/Adoptive Mother:					
Step/Adoptive Father:					

Other adults residing with the minor:

Name	Relationship to the Minor	Education	Occupation

Brothers and Sisters:

Name	Current Age	Natural, Step, Half or Adopted	Lives with Minor? Yes	No

Biological parents' date of marriage, if applicable: ____________ Date of divorce, if applicable: ____________

Remarriages and dates: Mother: ______________________________

Father: ______________________________

Other children residing with the minor:

Name	Age	Relationship

Admin/Forms/Clin(10/11; 11/15; 5/17; 12/17)

____
Patient Name (Account #)

INPUT OF PATIENT OR FAMILY

State in your own words the nature of the child/adolescent's present problems and previous difficulties: ___________________________

____

____

____

When were the problems/difficulties first noticed and by whom (i.e. doctor, family member, friend, teacher)? ________________________

____

____

What do you want the clinic to help you accomplish? ____

____

____

What do you want your child/adolescent to achieve in treatment?

Short Term ____

Long Term ____

Has the child/adolescent ever been seen at this clinic before? Yes ____ No ____

If yes, clinic location and approximate dates: ____

Describe the child/adolescent's positive qualities, strengths, aptitudes and interests: ____

____

____

PERSONAL HISTORY

			Yes	No
During pregnancy:	Rh problems?		______	______
	Alcohol, drug use?		______	______
	Diabetes?		______	______
	Toxemia?		______	______
	Length of term:	___________________		
During labor and birth:	1-3 hours labor?		______	______
	Over 12 hours labor?		______	______
	Breech presentation?		______	______
	Cesarean?		______	______
	Oxygen deprivation?		______	______
	Infections?		______	______
	Birth Weight?	________ lbs. _______oz.		

Other information regarding complications and problems and/or any comments you would like to make regarding the pregnancy

labor and birth: ____

If adopted, list child/adolescent's age at adoption and name of agency facilitating the adoption:

____

EARLY DEVELOPMENT

		Yes	No
Feeding problems during infancy?		________	________
Age toilet training began:	_______months		
Age toilet training complete:	_______months		

Any problems related to toilet training?	________	________
Have there been problems with toilet use?	________	________
Any sleep problems (insomnia, night terrors, excessive sleep, etc.)?	________	________
Does the child have own bedroom?	________	________
Does the child share a bedroom?	________	________
Does the child share a bed?	________	________
Any delays in developmental milestones (sitting, walking, talking)?	________	________
Does child tend to play alone?	________	________
Age at onset of menstruation, if applicable: __________years		
Any menstrual problems?	________	________
Ever been described as hyperactive or withdrawn?	________	________
Any gross motor coordination problems (awkwardness, clumsiness)?	________	________
Any fine motor coordination problems or writing difficulty?	________	________
Any problems with speech?	________	________
Any problems with hearing?	________	________
Any language problems?	________	________
Any visual or perceptual problems?	________	________
Have any immunization shots been missed?	________	________

For every question answered "Yes," please provide further details:
____

MEDICAL INFORMATION	**Yes**	**No**
Any childhood diseases (measles, mumps, chicken pox)?	________	________
Any hospitalization(s)?	________	________
Any disabilities, limitations or ailments at this time?	________	________
Any convulsive disorder?	________	________
Any mental disorder in extended family?	________	________
Any alcohol or drug abuse in extended family?	________	________
Any involvement with alcohol or illicit drugs by the child/adolescent?	________	________
Allergies/Sensitivities, if Yes, list below	________	________

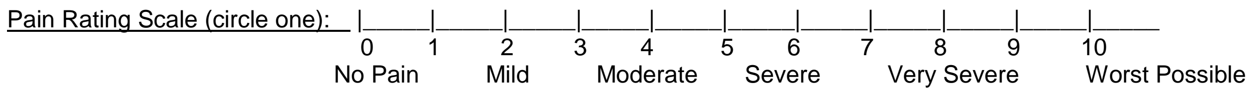
Medication Allergies: ____

Food Allergies: ____

Environmental Allergies: ____

Is the child experiencing any physical pain? □ Yes □ No Area of pain: ________________________________

Pain Rating Scale (circle one):



Is this pain being addressed? □ Yes □ No If yes, how? ________________________________

If no, why not? ____

For every question answered "Yes," please provide further details: ________________________________
____
____

Name and address of family physician: ____
____

Date and reason for most recent visit to a medical doctor: ________________________________

Date of last physical examination: ____

____
Patient Name (Account #)

List names and visit dates of all professionals that have been involved with the problems/difficulties for which treatment is being sought at this time: ____

____

List previous mental health/substance abuse treatment:

Facility/Provider(s)____ Date(s) ____________________

____ ____________________

Any LGBTQ or gender identity concerns? ☐ No ☐ Yes, please explain:________________________________

____

____

____

SCHOOL/SOCIAL ADJUSTMENT

At what age was school (of any kind) entered? ____

Have there ever been any difficulties in school? ____

____

____

Has minor attended Special Education classes? Yes ______ No _______

If yes, is patient currently attending and when did these services begin? ______________________________

Current grade level (please circle): K 1 2 3 4 5 6 7 8 9 10 11 12

Name and address of present school: ____

____

Name of school official to contact regarding school performance (contact can be made only after consent is given on a proper Release Form): ____

Has there ever been any trouble with the law? Yes ______ No _______

If yes, state instances and dates ____

____

Work/Employment history: ____

____

How are you related to this minor? ____

Parent/Guardian Signature: ________________________________ Date: ____________________

Printed Name:____

________________________________ ____________________
Therapist Review Date

NOTE: This Confidential History Form constitutes a data-gathering document that is part of the patient's Comprehensive or Biopsychosocial Assessment.