Biographical History Form – Child/Adolescent

First Name:	Middle Name:	Last Name:	Address:
Child's Age:	Child's DOB: ___ /___ /___	❑ Male ❑ Female	Today's Date: ___ /___ /___
Mother/Guardian:	Cell #: Home#:	Occupation: Business:	E-Mail:
Father/Guardian:	Cell #: Home#:	Occupation: Business:	E-Mail:
Languages Spoken: ❑ English ❑ Spanish ❑ Hebrew ❑ Creole ❑ French ❑ Other _________ Primary language at home: ___________	Ethnicity: ❑ White/Caucasian ❑ African/American ❑ Latino/Hispanic ❑ Native American ❑ Jamaican ❑ Haitian ❑ Multiracial ❑ Other _________	The parents: ❑ Marriage Intact ❑ Separated ❑ Divorced ❑ Remarried ❑ Deceased How long?___________ ___________________ ___________________	Who does the child live with?: ❑ Family ❑ Shared Custody ❑ Single Parent ❑ Guardian ❑ Other ________ _________________ _________________
Referred by: ❑ School ❑ Physician ❑ Therapist ❑ Insurance Co. ❑ EAP ❑ Family Member ❑ Friend ❑ Internet _______ ❑ Other _________	Was/Is your child?: ❑ Born Natural ❑ Born C-Section ❑ IVF ❑ Birth Complications ❑ Adopted ❑ Foster Child ❑ Other _________ ___________________	Prenatal/Neonatal: ❑ Healthy Mom ❑ Healthy Infant ❑ High Risk Preg. ❑ Labor Induced ❑ Premature ❑ NICU _________ ❑ Jaundiced ❑ Other _________ __________________	Initial Medical: ❑ No Concerns ❑ Colicky ❑ Speech Delays ❑ Hearing Problems ❑ Allergies ❑ Chronic Illness ❑ Other_________ _________________

When a baby: ❑ Smiled often ❑ Easy to soothe ❑ Adapted well ❑ Difficult to soothe ❑ Excessively cried ❑ Other _________ ___________________	What Age? Sat alone _________ Crawled __________ Walked ___________ Combined words ___________________ Toilet Trained ____ Dressed Self _____ Homework Alone __________________	Concerns During infancy: _____________________ _____________________ _____________________ _____________________ _____________________ _____________________ _____________________ _____________________ ____________________	As a toddler: ❑ Compliant ❑ Quiet ❑ Stubborn ❑ Independent ❑ Aggressive ❑ Friendly ❑ Shy/Timid ❑ Affectionate ❑ Other ________
Kindergarten began: ❑ On Time ❑ Delayed ❑ Repeated ❑ Other__________ _______________	Current School information: ❑ Public ❑ Private Grade______________ School Name ___________________	When with peers: ❑ Leader ❑ Follower ❑ Shy/Timid ❑ Friendly ❑ Aggressive ❑ Other__________	My child has been: ❑ Bullied by peers ❑ Abused ❑ Had losses ❑ Sibling rivalry ❑ Skipping school ❑ Other_________
Developmental: ❑ Speech Delay ❑ Diff. Hearing ❑ Language Delay ❑ Visual Problems ❑ Emotional Delay ❑ Social Problems ❑ Other _________ ___________________	Educational: ❑ Reading Issues ❑ Writing Problems ❑ Math Challenges ❑ ADHD symptoms ❑ Current IEP ❑ Accommodations ❑ Other _________ ___________________	Behavioral: ❑ Biting ❑ Hitting ❑ Tantrums ❑ Bullying ❑ Rebelling ❑ Fighting ❑ Stealing ❑ Other __________	Emotional: ❑ Anxiety ❑ Frustration Problems ❑ Over-Reactive ❑ Over-Sensitive ❑ Diff. Adjusting ❑ Diff. Sharing ❑ Other_________
Current Time: ❑ Play Alone ❑ Play w/ Sibling ❑ Play w/Peers ❑ Play w/Adults Which one is most frequent? ___________________	Current Activities: __________________ __________________ __________________ __________________ __________________ __________________ __________________ __________________	Child's Substance Use (past 30 days): ❑ Caffeine ❑ Cigarettes ❑ Alcohol ❑ Marijuana ❑ Prescription ❑ Over the Counter ❑ Street Drugs ❑ Other _________	Amount/Frequency ← __________________ __________________ __________________ __________________ __________________ __________________ __________________ __________________

Psych History: Individual Therapy:	Family Therapy:	Group Therapy:	Psychiatric History:
Diagnosis Known:	History of suicidal thoughts?: History of suicidal attempts?:	Psychiatric ER Visit: Psychiatric Hospitalization:	Family Psychological or Psychiatric History:
Medical History: Pediatrician's Name: Pediatrician's #: Last Dr visit: Results of exam	Medical Concerns:	Major Illnesses:	Medical Hospitalizations:
Surgeries:	Medical Challenges: ❑ Sleep Problems ❑ Eating Problems	Specialists:	Family Medical History:

Current Medication:	Dosage:	Times Per Day:	For Treatment of:
Legal History:	History of Abuse?:	Describe child's social network/support:	Describe child's present religious affiliation: Is this important to you?:__________
What are the reason(s) for your visit?:	How long has this problem persisted?:	Under what conditions do your problems usually get worse?:	Under what conditions are your problems usually improved?:
What are your therapy goals?:	What are your expectations?:	What are your child's strengths?:	Your child's weaknesses are:

Loses temper easily ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Argues with adults* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Irritates people* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Externalizes blame* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently
Easily annoyed ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Truant at school* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Hyperactive* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Loses things* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently
Easily distracted ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Interrupts others* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Poor grades* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Expelled* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently
Drug abuse ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Avoidant/shy* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Anxious/nervous* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Depression* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently
Fatigued ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Excessive worry* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Sleep problems* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Panic attacks* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently
Mood shifts ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Medical ailments* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Sibling rivalry* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently	*Phobias/fears* ❑ Never ❑ Rarely ❑ Sometimes ❑ Frequently

❑ Academic Problems ❑ Addictions ❑ ADHD ❑ Aggression	❑ Anxiety ❑ Avoidant Beh. ❑ Career Problem ❑ Compulsiveness ❑ Cultural Concern	❑ Depression ❑ Discrimination ❑ Dizziness ❑ Eating Disorder ❑ Elevated Mood	❑ Family Problem ❑ Fatigue ❑ Financial ❑ Hallucinations ❑ Harassment
❑ Identity Concern ❑ Internet Problem ❑ Impulsivity ❑ Intimacy Issues ❑ Interpersonal	❑ Irritability ❑ Judgment Errors ❑ Leal Concerns ❑ Loneliness ❑ Loss/Grief/Death	❑ Manic Episodes ❑ Medical Concern ❑ Memory Problems ❑ Mood Shifts ❑ Obsessive	❑ Panic Attacks ❑ Paranoia ❑ Phobias ❑ Physical Abuse ❑ Procrastination
❑ Recurring Thoughts ❑ Relationship ❑ Self Esteem ❑ Sexual Problems ❑ Sick Often	❑ Sleep Problems ❑ Speech Problems ❑ Spiritual Concern ❑ Stress/Tension ❑ Suicidal Thought ________________ ________________	❑ Thoughts Disorganized ❑ Thoughts Racing ❑ Trembling ❑ Trouble Making Decisions	❑ Withdrawing ❑ Worrying ❑ Other (specify) ________________ ________________ ________________

Please give examples of how each of the symptoms that you checked impairs your child's ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary____

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