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Adolescent History Questionnaire

Background Information

Child's Name
Date of Birth
Age
Address

Telephone #:
Parent e-mail
Grade
By whom were you referred?
Pediatrician's name and practice name

Insurance Company
Subscriber # on your insurance card
Subscriber Name
Subscriber Date of Birth
Subscriber's Employer

Parent 1: Name, age, occupation
Parent 2: Name, age, occupation
Siblings: Name, age

Are parents married, separated, divorced, or never married?

Others living in the home:

Other immediate family members who are not at home (e.g. noncustodial parent, older sibling at college):

Please describe your concerns:

When did these problems start?

Does anyone else in the family have similar difficulties? Please explain:

What questions are you hoping the evaluation can help to answer?

General Developmental History

Was your child born earlier than the usual nine months gestation?

Child's birth weight: pounds, ounces

Were there any medical problems during pregnancy, or during or after the birth?

What was your child like as an infant? (feeding, sleeping, etc.)

Did your child's development seem on target? Did he or she receive any Early Intervention services?

Please list the approximate age at which your child first:

Crawled
Sat up, without support
Walked without support
Spoke first word
Began putting words together
Was toilet trained

Is your child left- or right-handed?

Speech and Language History

What languages are spoken in your home? What is your primary language?

Was your child a quiet, average, or vocal infant?

Did your child begin to respond to his or her name, by age one?

Did your child point, to show you things, by age one?

Did you have any concerns about your child's early speech development?

Does your child have any difficulty communicating now? Please describe.

Please describe any concerns you have now, about your child's language skills.

Motor Skills

What kinds of active play and sports does your child enjoy?

Is there any physical activity which he or she avoids doing?

Anything physical at which he or she is better than average?

Was your child awkward or clumsy when he or she was younger?

Did he or she tire more easily than expected? How about now?

Is it difficult for your child to learn new motor skills? If yes, please describe.

Does your child have difficulties with handwriting or drawing? Does he or she have difficulty completing written work in school?

Sensory

Did your child have any unusual reactions to sights, sounds, or touch as a younger child? How about now?

Does your child avoid eye contact?

Was your child picky about food or clothing textures when younger? Now?

Does your child have any intense interests? If so, please describe.

Medical and Health History

Has your child had any serious illnesses, operations, or injuries?

Does he or she have any allergies?

Has your child been seen by any medical specialists? Please be specific.

Please list any medications, either prescription or over the counter:

Are there any other medical concerns about your child?

Do you have concerns about your child using drugs or alcohol?

Do you have any other concerns about your child engaging in risky behaviors?

Family History

Where was your child born?

Is he or she a biological, adopted, or foster child?

How does your child relate to family members?

Has anything traumatic happened in your child's life (such as separation from a parent, being in an accident, death of a relative)?

Do any relatives have learning disabilities, attention deficit disorder, or a mental health diagnosis such as anxiety or depression?

Social Development:

How does your child like to spend his or her time?

How would you describe your child's temperament?

How does your child interact with others his or her age?

How often does your child spend time with peers outside of school?

Does his or her attention span, or behavior, affect the ability to socialize with peers? Adults?

How does your child occupy him or herself when alone?

Educational History

Where does your child go to school?

Does your child receive any special educational services? If so, please list them.
How does your child feel about school?

What does your child like and dislike in school? Which subjects come easily and which are harder?

How do you feel about his or her present educational program?

Additional Information

Please describe your child's strengths and best qualities.

Please use the space below to discuss any other relevant information about your child or any other concerns which you might have.