# FAMILY PSYCHOLOGY ASSOCIATES, PC

## ADOLESCENT SOCIAL & DEVELOPMENTAL HISTORY (6/1/26)

Instructions: Please complete the following information about your adolescent and family. If any questions do not apply, simply write "DNA" (does not apply) in the space provided or leave the space blank. It is best if this form is completed by all parents or primary caretakers and by the adolescent. This information will be helpful to your adolescent's doctor or other professionals to better understand your child and your family.

*Adolescent name:*_____ *Age:*_____ *DOB:* _____ *Sex:* _____

*Address:* _____ *City:* _____ *Zip:* _____

*School:* _____ *In 504 plan?* ____ *Grade:* _____ *School Phone:* _____

Special Educational Services (e.g., Chapter 1, Resource Room, Tutoring) _____
Has the school or AEA evaluated child? (yes) (no) if yes — when? _____
Results: _____

Church affiliation: _____ Social involvement: _____

_____

Informant's Name and relationship to adolescent: _____

## FAMILY COMPOSITION: *Parent/Step-Parent/Guardian information*

Parent: _____ Address: _____

City: _____ Zip: _____ Hm# _____ Cell: _____ Wk# _____

Emp: _____ Days/Hours: _____ Highest Grade / Degree Completed: _____

Is this child your: __Biological child, ___adopted child or __foster child? ____Other? _____

Parent: _____ Address: _____

City: _____ Zip: _____ Hm# _____ Cell: _____ Wk# _____

Emp: _____ Days/Hours: _____ Highest Grade / Degree Completed: _____

Is this child your: __Biological child, ___adopted child or __foster child? ____Other? _____

With whom does this child live? _____

Who has legal custody of this child? _____

Other persons living in child's home:

| NAME | BIRTH DATE | AGE | EDUCATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## CURRENT CONCERNS:

What are you most concerned about regarding your adolescent that has led you to complete this history form? _____

_____

_____

Has there been a recent crisis or loss in your adolescent's life? Explain: _____

_____

What does your adolescent think about coming to therapy? (The adolescent is strongly encouraged to answer this question.)

_____

_____

# DEVELOPMENT and MEDICAL INFORMATION:

*Pregnancy:*

_____Smoking during pregnancy? ____# Cigarettes smoked per day _____Alcohol consumption during pregnancy
_____Other drug use during pregnancy? _____

*Delivery:*

_____Normal? _____Not normal? Explain: _____

*Post Delivery Period:*

____Normal ____Not normal? Explain: _____

*Infancy-Toddler Period:* Were any of the following present to a significant degree during the first few years of life?

Not enjoy cuddling Not calmed by being held or stroked Colic Diminished sleep Difficult to comfort
Excessive restlessness Excessively Irritable Frequent head banging Difficulty nursing /bottle
Difficulty adjusting to regular food

Comments: _____

*Milestones:* At what age did your child: ___Walk without support ____Speak single words ___Toilet trained

*Medical History:* Child's Physician: _____phone: _____
Date of last doctor visit: _____reason for visit: _____
Child's general health is: excellent good fair poor

Has your adolescent ever had any major medical problems? _____

_____

Present illnesses for which the adolescent is being treated:

_____

Psychotropic medications (stimulants, medications for ADHD, mood, anxiety medications) adolescent has been taking or is currently taking. Include name of medication and dosage. Current medications: _____

_____

Previous medications: _____

_____

Describe any benefit from these medications or adverse effects: _____

_____

_____

Has your adolescent ever received treatment by a mental health professional? If so, who provided this treatment, when, and what was the purpose of the treatment?

_____

# FAMILY INFORMATION & HISTORY:

*Use* the ***checklists below*** to ***describe*** *any family history of psychiatric and learning problems.* (in child's parents, grandparents, or siblings)

Aggressiveness / Defiance: (specify who) _____

Difficulties with attention / Hyperactivity as a child: (specify who) _____

Learning problems: (special) who) _____

Failed to graduate from high school: (specify who) _____

Intellectual Disability: _____

Psychosis or Schizophrenia: (specify who) _____

Depression: (specify who) _____

Tics or Tourette's syndrome: (specify who) _____

Alcohol abuse / Substance abuse: (specify who) _____

Arrests: (specify who) _____

Physical abuse / Sexual abuse: (specify who) _____

Nervous tension problem / anxiety: (specify who) _____

Temper problems: (specify who) _____

Suicide attempts: (specify who) _____

Attention Deficit / Hyperactivity Disorder: (specify who) _____

Hearing loss: (specify who) _____

Vision problems: (specify who) _____

Genetic Disorder: (specify who) _____

Developmental delays: (specify who) _____

Seizure Disorder: (specify who) _____

Antisocial behavior: (specify who) _____

In general, describe your adolescent's performance during elementary school. List any outstanding strengths or problems.

_____

_____

_____

_____

Describe your adolescent's performance during middle school and high school. List any outstanding strengths or problems.

_____

_____

_____

Has your child ever repeated a grade? ___If so, which grade? ___Comments: _____

Describe any problems your adolescent may have in school with learning. _____

_____

Describe any problems your adolescent may have with homework (e.g. forgets, does not return it to school, etc.) _____

_____

_____

# PARENTING TECHNIQUES

Describe any differences or similarities between each of the parent's management style in handling disruptive behavior.

Are your parenting strategies effective? Why or why not?

(For the adolescent to answer.) What do you appreciate and dislike about these parenting techniques?

# STRENGTHS AND ACCOMPLISHMENTS

*We realize that we have focused largely on problems that your child may be having. However, we are also quite interested in understanding your child's strengths, talents, skills, and accomplishments. Please use the space below to describe these assets and use additional pages if necessary.*