Julie B. Gowen PLLC
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CHILD/ADOLESCENT PSYCHOSOCIAL

IDENTIFYING INFORMATION:

Name of Child: _____ Today's Date: _____
DOB: ___/___/___ Age: _____ Grade: _____ Gender: ____ Male ____ Female
Address: (number and street): _____
City: _____ State: _____ Zip Code: _____
Telephone: _____ Religion: _____
Present School: _____
Information provided by: _____ Relationship to client: _____
Referral Source: _____

I give permission for Julie B. Gowen, LCSW to contact _____
Regarding treatment issues, symptoms, behaviors or other information necessary for the treatment of _____.

Parent/Guardian Signature: _____ Date: _____

CHIEF COMPLAINT: (Check all that apply)

___ Very unhappy
___ Irritable
___ Temper Outbursts
___ Withdrawn
___ Daydreaming
___ Fearful
___ Clumsy
___ Overactive
___ Slow
___ Short Attention Span
___ Distractible
___ Lacks Initiative
___ Undependable
___ Peer Conflict
___ Phobic
___ Impulsive
___ Stubborn
___ Disobedient
___ Infantile
___ Mean to Others
___ Destructive
___ Trouble w/the Law
___ Running Away
___ Self-Mutilating
___ Head Banging
___ Rocking
___ Shy
___ Strange Behavior
___ Strange Thoughts
___ Suicide Talk
___ Fire Setting
___ Stealing
___ Lying
___ Sexual Trouble
___ School Performance
___ Truancy
___ Bed Wetting
___ Soiled Pants
___ Eating Problems
___ Sleeping Problems
___ Sickly
___ Drug Use
___ Alcohol Use
___ Other: _____

Please Explain: _____
_____
_____

Describe:_____

_____

History of Current Problem:

_____

_____

How long have these problems occurred? (number of weeks, months, years)

_____

Previous Treatment: Whom/When: _____

Was previous treatment successful? ____ Yes ____ No How?

_____

How have you tried to solve the problem(s)?

_____

_____

Has child had any academic/psychological testing? ____ Yes ____ No

If yes, why: _____

By Whom: _____

When: _____ Do you have the results? ____ Yes ____ No

What has happened most recently that makes you seek help at this time?

_____

_____

Problems perceived to be: ____ very serious ____ serious ____ not serious

What are your expectations of your child? _____

_____

What changes would you like to see in your child? _____

_____

What changes would you like to see in yourself? _____

_____

What changes would you like to see in your family? _____

_____

FAMILY OF ORIGIN:

Parents: ____ Married ____ Separated ____ Divorced ____ Never Married

Mother: ____ Natural Parent ____ Step-Parent ____ Adoptive Parent ____ Relative

DOB: _____ Age: _____ Educational Level: _____

Marriages: _____

Occupation: _____

Drug/Alcohol Abuse: _____

Previous Pregnancies, Abortions, Miscarriages: _____

Mental Health Issues: _____
Medication(s): _____
Siblings: _____
_____
Maternal Grandparents: (Living, if deceased how? Divorced/Never Married/Remarried)
_____
_____
Family Psychiatric History: _____
_____
Family environment growing up: _____
_____
Religion: _____

Father: ____ Natural Parent ____ Step-Parent ____ Adoptive Parent ____ Relative
DOB: _____ Age: _____ Educational Level: _____
Marriages: _____
Occupation: _____
Drug/Alcohol Abuse: _____
Mental Health Issues: _____
Medication(s): _____
Siblings: _____
_____
Paternal Grandparents: (Living, if deceased how? Divorced/Never Married/Remarried)
_____
_____
Family Psychiatric History: _____
_____
Family environment growing up: _____
_____
Religion: _____

If Child is Adopted:
Adoption Source: _____
Reason and Circumstances: _____
Age when Child First in Home: _____ Date of Legal Adoption: _____
What has the child been told? _____
_____

Who does child get along with best/least? _____
Alliances: _____
Discipline Techniques/Efforts/Effective? _____
_____

Religious or Spiritual Affiliations: _____
Family attends together/separately: _____

LIVING ARRANGEMENTS: Places Dates
Number of moves in child/s life: _____ _____ _____
_____ _____
_____ _____
_____ _____

Present Home: ____ Renting ____ Buying
____ House ____ Apartment

Does the child share a room with anyone else? ____ Yes ____ No
If yes, with whom? _____
If no, how long has he/she had own room? _____
Does child sleep in his/her own room? ____ Yes ____ No
Was the child ever placed, boarded, or lived away from the family? ____ Yes ____ No
If yes, explain: _____
What are the major family stresses at the present time, if any? _____
_____
What are the sources of family income? _____
_____

Brothers and Sisters: (indicate if step or half-brothers or step or half-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at Home (Yes or No)	Drug or Alcohol Use (Yes or No)	Treated Drug or Alcohol (Yes or No)

Others living in the home (and their relationship):
1. _____
2. _____
3. _____
4. _____

List all other extended family members by their relation to the child who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems:

1. _____
2. _____
3. _____
4. _____

Health of Family Members: (excluding minor child to be seen)

Name	Relationship to Child	Type of Illness	When Occurred	Length of Illness

DEVELOPMENTAL HISTORY:

Prenatal – Child wanted? ____ Yes ____ No Planned for? ____ Yes ____ No
Normal Pregnancy? ____ Yes ____ No
Medical complications of mother during pregnancy? ____ Yes ____ No

Please describe nature of complications or illness mother had during pregnancy:

_____
_____
_____

Was the father's family supportive and accepting during pregnancy? Describe any problems:

_____

Was the mother's family supportive and accepting during pregnancy? Describe any problems:

_____

BIRTH:

Length of active labor: _____ Hours ____ Easy ____ Difficult
Full Term: ____ Yes ____ No
If premature, how early? _____
If overdue, how late? _____
Birth Weight: _____ Pounds _____ Ounces
Type of Delivery: ____ Spontaneous ____ Cesarean ____ With Instruments
____ Head First ____ Breech
Was it necessary to give the infant oxygen ____ Yes ____ No If yes, how long: _____
Did infant require blood transfusion? ____ Yes ____ No

Did infant require special medical
treatment? ____ Yes ____ No
Did mother use alcohol/drugs
during pregnancy? ____ Yes ____ No
Did mother and baby bond? ____ Yes ____ No
Comments: _____

NEWBORN PERIOD:

			How Long
Irritability	____ Yes	____ No	_____
Vomiting	____ Yes	____ No	_____
Difficulty Breathing	____ Yes	____ No	_____
Difficulty Sleeping	____ Yes	____ No	_____
Convulsions/Twitching	____ Yes	____ No	_____
Colic	____ Yes	____ No	_____
Normal Weight Gain	____ Yes	____ No	_____
Was Child Breast Fed	____ Yes	____ No	_____
Other: _____	____ Yes	____ No	_____

Mood of Baby ____ Cuddly ____ Aloof ____ Pushed Away
Comments: _____

AT WHAT AGE CHILD:
Sat Up: _____
Crawled: _____ Crawled before walking? ____ Yes ____ No
Walked: _____
Spoke Single Words: _____
Sentences: _____
Bladder Trained: _____ ____ Easy ____ Difficult Explain: _____
Bowel Trained: _____ ____ Easy ____ Difficult Explain: _____
Weaned: _____ ____ Easy ____ Difficult Explain: _____

Primary Caretaker(s): _____
_____

EARLY SOCIAL DEVELOPMENT:
Relationship to siblings and peers:

____ have a best friend, for how long? _____
____ Individual Play ____ Group Play
____ Competitive ____ Cooperative
____ Leadership Role ____ Follower

Describe any concerning habits, fears, or unusual behaviors your child has now or had in the past: _____
_____
_____

Strengths: _____
Weaknesses: _____

EDUCATIONAL HISTORY:
Number of schools child has attended: _____

Name of School	City/State	From/To	Grades Completed At This School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Types of Classes: ____ Regular Education ____ Special Education
Did child skip a grade? ____ Yes ____ No Repeat a grade? ____ Yes ____ No
Did child have any specific learning difficulties? ____ Yes ____ No
If yes, describe: _____
Has child ever been identified as emotionally disturbed by school personnel? ____ Yes ____ No
If yes, please describe: _____
Has child ever had a tutor or other special help with schoolwork? ____ Yes ____ No
Does child attend school on a regular basis? ____ Yes ____ No
Does child appear motivated for school? ____ Yes ____ No
Has child ever been suspended or expelled? ____ Yes ____ No

ACADEMIC PERFORMANCE:
Highest grade on last report card? _____ Lowest grade on last report card? _____
Favorite subject(s): _____
Least favorite subject(s): _____
Does child participate in extracurricular activities? ____ Yes ____ No
If yes, which activities? _____
In school, how many friends does child have? ____ a lot ____ a few ____ none
What are child's educational aspirations? ____ quit school
____ graduate from high school
____ go to college

List child's special interests, hobbies, skills: _____
_____
_____

Has the child ever had difficulty with the police? ____ Yes ____ No
If yes, please explain: _____
Has the child ever appeared in juvenile court? ____ Yes ____ No
If yes, please explain: _____
Has child ever been on probation? ____ Yes ____ No
If yes, please explain: _____

Dates (From-To)	**Reason**	**Probation Officer**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has child protective services ever been involved with the child/family/siblings? ___ Yes ___No
If Yes: What Reason? _____
Caseworker: _____ Phone: _____
Has case been closed? ____ Yes ____ No If yes, when: _____
Has counseling been a requirement? ____ Yes ____ No
Has child ever been employed? ____ Yes ____ No

Position	**Employer**	**How Long**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is there any other information you have not already included that you believe would be helpful for me to know? _____
_____
_____
_____
_____

Relationship of Person Completing this Form:
____ Mother ____ Father ____ Grandmother ____ Grandfather ____ Foster Parent
____ Other: _____

Signature: _____ Legal Guardian? ____ Yes ____ No