SHEILA SIMPSON-CREPS MA, LMHC, MFA
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Child Developmental History Record

Today's date: _____

Client Name: _____Birth Date: _____

Name of parent/legal guardian: _____

CHILD/ADOLESCENT INTAKE FORM

PRESENTING PROBLEMS AND CONCERNS

Please describe the problem that brought you here today:

_____
_____
_____

Please check all your child's behaviors and symptoms that you consider problematic:

Distractibility	Homicidal thoughts	Fire setting	Wide mood swings
Change in appetite	Suicidal thoughts	Thoughts of death	Swearing
Visual hallucinations	Sleep problems	Obsessive thoughts	Computer addiction
Manipulative behavior	Poor memory/confusion	Stealing	Low self-worth
Hyperactivity	Fear away from home	Work/school problems	Suspicion/paranoia
Withdrawal from people	Frequent arguments	Self-harm behaviors	Curfew violations
Defiance	Nightmares	Compulsive behavior	Loneliness
No/few friends	Sadness/depression	Destroys property	Fatigue
Impulsivity	Social discomfort	Legal problems	Hearing voices
Anxiety/worry	Irritability/anger	Crying spells	Lying
Aggression/fights	Toileting problems	Racing thoughts	Lack of motivation
Eating problems	Hopelessness	Running away	Recurring, disturbing memories
Boredom	Phobias	Sexual behavior	
Panic attacks	Peer/sibling conflict	Alcohol/Drug Use	

Alcohol/Drug Use (please list substance, and use history below)

_____
_____
_____

How long with problematic symptoms/behaviors? (check one)

____ Less than 1 month ____1- 6 mos ____6 -11 mos ____1-2 yrs ____3-5 yrs ____ 6 + yrs

Are your child's problems affecting any of the following?

Handling everyday tasks	Self-esteem	Relationships
Hygiene	Health	Recreational activities
Work/School	Housing	Legal matters
Finances		

Has your child ever had thoughts, made statements, or attempted to hurt him/herself? ___No ___ Yes

If yes, please describe:

_____
_____

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Has your child ever had thoughts, made statements, or attempted to hurt someone else? ____No ____ Yes If yes, please describe: _____
_____

Has your child recently been physically hurt or threatened by someone else? ____No ____ Yes If yes, please describe: _____
_____
_____

Has your child gambled in the past 6 months? ___No ___ Yes If yes, let us know the following: **____No ____Yes** Has your child ever felt the need to bet more and more money? **____No ____ Yes** Has your child ever had to lie to people about how much your child has gambled?

FAMILY AND DEVELOPMENTAL HISTORY

Family Mental Health Problems	Family Member
ADHD	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse/Drug Abuse	

Were there any medical problems during the pregnancy or birth of your child? ____No ____ Yes
If yes, please describe:
_____
_____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? ____No ____ Yes If yes, please describes substances used, quantity, and frequency:
_____

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? ____No ____ Yes If yes, please describe:_____
_____

PREVIOUS MENTAL HEALTH TREATMENT

	Type of Treatment	Dates	Provider	Reason for Treatment
	Outpatient Counseling			
	Psychiatric Hospitalization			
	Drug/Alcohol Treatment			
	Medication (mental health)			

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SCHOOL INFORMATION
Current grade/placement: _____
This year's school *grades*: ___Excellent ____Good ____Fair ____Poor
Past school *grades*: ___Excellent ____Good ____Fair ____Poor
This year's school *behavior*: ___Excellent ____Good ____Fair ____Poor
Past school *behavior*: ___Excellent ____Good ____Fair ____Poor
Has your child had any of the following difficulties at school?
_____Suspension _____Incomplete homework _____Learning problems _____Referrals or detentions
_____Poor grades _____Teased or picked on _____Speech problems _____Attendance problems
_____Gang influence
Does your child have an after-school provider? ____No ____ Yes If so, who? _____
Has your child ever repeated or skipped a grade? ____No ____ Yes If yes, which one(s)?_____
Has your child ever received Special Education services or have an IEP? ____No ____ Yes
If yes, please describe: _____

Health
List all childhood illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions.

Condition Age Treated by whom? Consequences?
_____
_____
_____

Residences
1. Homes
Dates: From To Location With whom Reason for moving Any problems?
_____
_____
_____

2. Residential placements, institutional placements, or foster care

Dates
From to Program name or location Reason for placement Problems?
_____
_____
_____

Special skills or talents of child
List hobbies, sports; recreational, musical, TV, and toy preferences; etc.:
_____

Other
Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important? If the child is adopted or in foster care, please include dates of adoption, number of foster placements etc.) (*If more room is needed please use the other side of this page).*
_____
_____