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CHILD PSYCHOLOGICAL HISTORY

Child's Name _____ Date _____

Parent/guardian Tel: (Cell) _____ (work) _____

Age _____ Birthdate _____ Religion (optional) _____

Sex _____ Ethnic or racial background _____

Grade and school _____

Hand child uses for writing or drawing: Right Left Switches between them

Primary language _____ Secondary language _____

Previous diagnosis (1) _____

If any (2) _____

Who referred you to our office? _____

Briefly describe the problem: _____

What specific concerns do you have?

(1) _____

(2) _____

(3) _____

THIS FORM HAS BEEN COMPLETED BY:

Name _____ Relationship to child _____

Address _____

Phone (C) _____ (W) _____

SYMPTOM SURVEY

For each symptom that applies to the child, place a check. Compare the child to other children of the same age. Add any helpful comments next to the item.

1) PROBLEM SOLVING

- Difficulty figuring out how to do new things
- Difficulty making decisions
- Difficulty planning ahead
- Difficulty solving problems a younger child can do
- Disorganized in his/her approach to problems
- Difficulty understanding explanations
- Difficulty doing things in the right order (sequencing)
- Difficulty verbally describing the steps involved in doing something
- Difficulty changing a plan or activity in a reasonable period of time
- Is slow to learn new things
- Difficulty switching from one activity to another activity
- Easily frustrated
- Other problem solving difficulties _____

2) SPEECH, LANGUAGE, AND MATH SKILLS

- Difficulty speaking clearly
- Difficulty finding the right word to say
- Not talking
- Rambles on and on without saying much
- Jumps from topic to topic
- Odd or unusual language or vocal sounds
- Difficulty understanding what others are saying
- Difficulty in writing letters or words
- Difficulty reading letters or words
- Difficulty with spelling
- Difficulty with math
- Other speech, language, or math problems: _____

3) AWARENESS AND CONCENTRATION

- Easily distracted by: Sounds Sights Physical sensations
- Mind appears to go blank at times
- Loses train of thought
- Difficulty concentrating on what others say, but can sit in front of a TV for long periods
- Attention starts out OK but can't keep it up
- Other attention or concentration problems: _____

4) MEMORY

- Forgets where he/she leaves things
- Forgets things that happened recently (e.g., last meal)
- Forgets things that happened days/weeks ago
- Forgets what he/she is supposed to be doing
- Forgets names more than most people do
- Forgets school assignments
- Forgets instructions
- Other memory problems: _____

5) BEHAVIOR

- | | |
|---|--|
| <input type="checkbox"/> Aggressive | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Attached to things, not people | <input type="checkbox"/> Nightmares, night terrors, sleepwalks |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Quiet |
| <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Resists change |
| <input type="checkbox"/> Bowel movement in underwear | <input type="checkbox"/> Risk-taking |
| <input type="checkbox"/> Dependent | <input type="checkbox"/> Self-mutilates |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Self-stimulates |
| <input type="checkbox"/> Eating habits are poor | <input type="checkbox"/> Shy and withdrawn |
| <input type="checkbox"/> Emotional | <input type="checkbox"/> Sleeping habits are poor |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Swears a lot |
| <input type="checkbox"/> Immature | <input type="checkbox"/> Unmotivated |
| <input type="checkbox"/> Other unusual behavior: _____ | |

Below check all the descriptions of the child that have been present for at least the **past 6 months**.
These behaviors should occur more frequently than in other children of the same age.

- | | |
|---|---|
| <input type="checkbox"/> Is very fidgety | <input type="checkbox"/> Steals things without people knowing on several occasions |
| <input type="checkbox"/> Can't remain seated | <input type="checkbox"/> Often runs away from his parents' home and stays away overnight |
| <input type="checkbox"/> Highly distractible | <input type="checkbox"/> Easily lies to others |
| <input type="checkbox"/> Can't wait for his/her turn when playing with others | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Answers before he/she hears the whole question | <input type="checkbox"/> Doesn't go to school |
| <input type="checkbox"/> Rarely follows others' instructions | <input type="checkbox"/> Breaks into other people's property |
| <input type="checkbox"/> Has a hard time concentrating for long periods | <input type="checkbox"/> Destroys other people's property in some manner other than by fire |
| <input type="checkbox"/> Goes from one activity to another without finishing anything | <input type="checkbox"/> Seems like he/she is always talking |
| <input type="checkbox"/> Frequently makes noise when playing | <input type="checkbox"/> Is cruel to animals |
| <input type="checkbox"/> Is often rude or interrupts others | <input type="checkbox"/> Has forcible sexual relations with others |
| <input type="checkbox"/> Doesn't listen to other people | <input type="checkbox"/> Starts fights with others |
| <input type="checkbox"/> Seems like he/she frequently is losing things that are needed for school | <input type="checkbox"/> Will steal directly from people |

- 6) Overall, the child's symptoms have developed: Slowly Quickly
- 7) The symptoms occur: Occasionally Often
- 8) Over the past 6 months the symptoms have: Stayed about the same Worsened

PREGNANCY

9) Mother's age at child's birth: _____ Father's age at child's birth: _____

10) **Before** the pregnancy, what medications (prescribed or over-the-counter) did the mother take?

List all medications used: _____

11) **While** pregnant, what medications (prescribed or over-the-counter) did the mother take?

List all medications used: _____

12) During the pregnancy, which of the following did the mother use?

	Amount and Daily Frequency
<input type="checkbox"/> Alcohol	_____
<input type="checkbox"/> Caffeine	_____
<input type="checkbox"/> Marijuana	_____
<input type="checkbox"/> Recreational drugs (cocaine, heroin, etc.)	_____
<input type="checkbox"/> Tobacco	_____

13) During the pregnancy, the mother's diet was: Good Poor

If poor, explain: _____

14) The mother's general physical health during the pregnancy was: Good Poor

If poor, explain: _____

15) About how much weight did the mother gain while she was pregnant? _____ lbs.

16) During this pregnancy, check all the mother had:

- Accident
- Anemia
- Bleeding (severe or frequent spotting)
- Diabetes
- High blood pressure
- Preeclampsia, eclampsia, or toxemia
- Psychological problems
- Surgery
- Vomiting (severe or frequent)

17) How many pregnancies did the mother have prior to this one?

Number of live births: _____

Number of miscarriages: _____

BIRTH

18) Was this child born:

Early How early? _____ weeks

On time (38-42 weeks)

Late How late? _____ weeks

19) How much did the baby weigh at birth? _____ lbs. _____ oz or _____ gms.

20) How long did the labor last? _____

21) The labor was: Easy Moderately difficult Very difficult

22) What type of medication was the mother given to help with the delivery?

None Demerol Gas Regional nerve (spinal block) Tranquilizer Epidural

23) Were forceps used during delivery? Yes No

24) Was the baby born:

Head first Transverse(crosswise) Posterior first

Breech birth Caesarean section Vacuum extraction

Other: _____

25) Did the baby experience any of these problems:

Fetal distress Low placenta (Placenta previa) Prolapsed cord

Premature separation of placenta (Abrupto placenta) Cord wrapped around neck

26) Describe any other special problems the mother or child had during delivery:

27) At birth, did the baby:

Have difficulty breathing? Yes No

Fail to cry? Yes No

Appear inactive? Yes No

28) List the baby's Apgar scores: 1st _____ 2nd _____

29) If the father or the mother noticed anything unusual when they first saw the baby, describe:

If the baby was born with any problems (congenital defects, large or small head, blue baby, bleeding in brain, etc, describe: _____

Describe any special problems that the baby had in the first few days following birth:

Describe any special care, treatment, or equipment the child was given after birth:

How long did the baby stay in the hospital? _____

DEVELOPMENTAL HISTORY

30) For each area, indicate the child’s development by circling one description. The “average” period is only a rough idea of what is average since every developmental milestone actually involves a range of several months (e.g. walking occurs approximately 9-18 months of age). Circle “early” or “late” only if you are sure the child’s development was different from that of most other children.

GROSS MOTOR SKILLS

Crawled	Early	Average (6-9 mos)	Late
Walked alone (2-3 steps)	Early	Average (9-18 mos)	Late

LANGUAGE

Followed simple commands	Early	Average (12-18 mos)	Late
Used single-word sentences	Early	Average (12-24 mos)	Late

SELF-HELP

Toilet trained	Early	Average (13-36 mos)	Late
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31) Toilet training was:

- Easy
- Difficult

32) As an infant or toddler, the child was:

- Too calm and inactive
- Calm and reasonably active
- Irritable and very active

33) As a toddler, the child was:

- Shy and inhibited
- Neither shy nor outgoing
- Very outgoing and liked people

34) Has the child ever been hit hard on the head or suffered a head injury? Yes No

If yes, what age(s)? _____ Did the child lose consciousness? Yes No

How did it happen? _____

What problems did the child have (physical or mental) afterwards?

35) Has the child been diagnosed with seizures or epilepsy? Yes No
 If yes, which type? Partial seizure Generalized seizure Unclassified type
 If medication is used, which medication(s)? _____
 Has the child ever had a bad reaction to this medication? Yes No
 If yes, describe: _____
 Did the child ever have a seizure due to a fever or unknown cause? Yes No
 If yes, describe (age, nature of seizure): _____

36) Was the child ever in the hospital for an accident, injury or operation? Yes No
 If yes, what age(s)? _____ What happened? _____

37) Has the child ever swallowed any poison, non-food, or drug accidentally? Yes No
 If yes, what age(s)? _____ What happened? _____

38) Did the child have frequent ear infections? Yes No
 If yes, what age(s)? _____ How often and severe? _____
 What treatment was provided? _____

39) List all the medications the child takes now:

Medication	Dosage	How often?	What for?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

40) What is the child's :
 Height _____ft. _____in. Weight: _____lbs.

41) When was the child's last medical check-up? _____

FAMILY HISTORY

42) The child lives with:

- Biological parent(s) only Relatives Foster parents
 Biological parent and other Adoptive parents Institutional care
 Other placement: _____

43) The family's income is:

- under \$10,000 \$10,000-\$29,999 \$30,000-\$50,000 over \$50,000

44) What is the name of the child's biological mother? _____

- a. Is she living? Yes No If deceased, explain: _____
b. Her age? _____
c. What is her level of education? _____
d. Her occupation? _____
e. Does she live in the same house as the child? Yes No
f. How often does she see the child? _____
g. How involved is the mother in the child's upbringing? Very Somewhat Not at all
h. Did the mother have a learning disability or other problems when she was in school?
Yes No If yes, describe: _____
i. What are the mother's hobbies? _____

45) What is the name of the child's biological father? _____

- a. Is he living? Yes No If deceased, explain: _____
b. His age? _____
c. What is his level of education? _____
d. His occupation? _____
e. Does he live in the same house as the child? Yes No
f. How often does he see the child? _____
g. How involved is the father in the child's upbringing? Very Somewhat Not at all
h. Did the father have a learning disability or other problems when she was in school?
Yes No If yes, describe: _____
i. What are the father's hobbies? _____

46) Please list the names, ages, and grade (or job) of the child's brothers and sister:

Name	Age	Grade or job
_____	_____	_____
_____	_____	_____
_____	_____	_____

47) Has anyone in the child's biological family (including parents, grandparents, siblings, aunts & uncles) ever had any of the following:

	Which relative?	Describe the problem briefly
<input type="checkbox"/> Brain disease	_____	_____
<input type="checkbox"/> Developmental delay	_____	_____
<input type="checkbox"/> Epilepsy or seizures	_____	_____
<input type="checkbox"/> Learning disability	_____	_____
<input type="checkbox"/> Attention problems	_____	_____
<input type="checkbox"/> Neurological disease	_____	_____
<input type="checkbox"/> Psychological problems	_____	_____
<input type="checkbox"/> Reading or spelling difficulties	_____	_____
<input type="checkbox"/> Speech or language problems	_____	_____

48) What languages are spoken in the home? (list in order of the most frequent first)

1) _____ 2) _____

49) How is the child disciplined? _____

50) List the child's usual recreational activities and hobbies: _____

51) Have there been any major family stresses or changes in the past year (e.g. moving with change of school, divorce, significant illness, etc)?

Yes No If yes, explain: _____

How much stress have these changes caused the child? (circle one)

None Mild Moderate Severe

SCHOOL HISTORY

52) The child's present school is: Name: _____
Address: _____
Phone: _____ Contact person: _____

53) Was the child ever held back to repeat a grade? Yes No

If yes, which grade? _____ Why? _____

54) Has the child ever been in a special class or provided with special services (e.g. resource room, EMR, learning disability class, etc.)? Yes No

If yes, describe the special class: _____

Is the child in this class or receiving special services now? Yes No

55) Does the child like school? Most of the time Some of the time Almost never

56) Does the child:

Have problems with other children in class? Yes No

Have problems making friends in school? Yes No

Have problems getting along with teachers? Yes No

Tend to get sick in the morning before school? Yes No

57) Describe the teacher's concerns about the child's schoolwork or behavior:

58) What kind of grades has the child received in the past year?

A's & B's B's & C's C's & D's D's & F's

or Outstanding Good Satisfactory Improvement needed Unsatisfactory

or Other grading system: _____

Are these grades a change from previous years? Yes No

