DEBORAH S. LYONS Ph.D.

4310 Medical Parkway, Suite 103 Austin, TX 78756
512.459.1272 ❧dlyonsphd@gmail.com
www.deborahslyonsphd.com

Today's Date: _____

CHILD AND ADOLESCENT PATIENT HISTORY FORM

Last Name:		**First Name:**	
Gender:	**DOB:**	**Age:**	**Race:**
Referred By:			

Mother's Name(s): _____

Father's Name(s): _____

Stepmother's Name: _____

Stepfather's Name: _____

Name of Legal Guardian: _____

Are you involved in any litigation with the other parent?

☐ No ☐ Yes (Indicate below)

☐ Divorce

☐ Post-divorce modification

☐ Litigation

If so, who is the attorney for:

Yourself? _____

Other parent? _____

Are there/have there been any court orders pertinent to the child:

☐ No ☐ Yes **PROVIDE COPIES**

Are you and the other parent in agreement about having named child(ren) in therapy?

☐ Yes ☐ No (Please explain)

_____

_____

_____

IDENTIFYING COMPLAINT:

Please identify the reason you are seeking treatment:

_____

_____

_____

_____

When did the problem(s) begin?

_____

_____

_____

_____

List anything you did to improve the problem:

_____

_____

_____

_____

Section1

FAMILY/ENVIRONMENTAL FACTORS

Are the biological parents:

☐ Divorced ☐ Separated ☐ Widowed

If so, at what age was your child when these events occurred? _____

If divorced, who has legal custody? **Please provide a copy of this section of your divorce decree.**

_____

If divorced, who has the right to make psychological treatment decisions? _____

If divorced, how much time does the child spend with each parent?

_____

_____

Is mother employed outside of the home? ☐YES ☐NO If so, where:

Job Title: _____ **☐ Full Time ☐ Part Time**

Employer: _____ **Length of Employment: _____**

Mother's highest grade/degree completed: _____

Is father employed outside of the home? ☐YES ☐NO If so, where:

Job Title: _____ **☐ Full Time ☐ Part Time**

Employer: _____ **Length of Employment:_____**

Father's highest grade/degree completed: _____

Are there any stressors or problems in the family at the present time that might affect the child?

☐ Marital Separation	☐ Divorce	☐ Legal/Criminal Matters
☐ Re-Marriage	☐ Relocation	☐ Financial Problem
☐ Unemployment	☐ Death	☐ Serious Physical/Mental Illness
☐ Chemical Dependency	☐ Pregnancy/birth	☐ Abuse

☐ Other:_____

Is English the child's first language? ☐YES ☐NO Explain:

_____

If not, when did the child learn to speak English? _____

What is the primary language used in the home? _____

Section 2

CHILD-REARING INFORMATION

Who cared for the child during the first two years of life? Describe changes in caretakers.

_____

_____

_____

Are both parents currently involved in the child's care? ☐YES ☐NO

Who stays with the child when the child is ill? _____

Does the child have a close relationship with an adult not presently living in the home? If so, identify that adult and explain:

_____

_____

_____

Who usually disciplines the child? _____

What forms of discipline do you use?

_____

_____

_____

Do both parents usually agree on discipline? ☐YES ☐NO If not, elaborate:

_____

_____

_____

Do you have support in the area to help with the child's care? ☐YES ☐NO Explain:

_____

_____

Where do you turn for suggestions and information regarding parenting?

_____

_____

What kinds of activities do you do together as a family?

_____

_____

_____

Does the child seem to have a closer relationship with one parent over the other, or with an adult who is not a parent? ☐YES ☐NO IF yes, identify that adult and explain:

_____

_____

Section 3

EDUCATIONAL BACKGROUND/SOCIAL INFORMATION

School Attending: _____ **Grade:** _____

Special Education Services: ☐**YES** ☐**NO** **Section 504 Services:** ☐**YES** ☐**NO**

Favorite subject(s): _____

Weakest subject area:_____

Has your child ever repeated or skipped a grade level? □YES □NO

Previous school(s) attended: _____

Did your child attend daycare? □YES □NO If so, at what age(s)?

_____

Did your child attend preschool? □YES □NO If so, at what age(s)?

_____

Does your child attend after school care? □YES □NO If so, how often?

_____

Who watches your child after school hours?_____

What does your child do after school?

_____

Does your child play outside in the neighborhood? □YES □NO

How does your child get along with peers?

_____

What activities does your child enjoy?

_____

What kind of jobs or household responsibilities does your child have?

_____

Are they done willingly? □YES □NO

Are they done without prompting? □YES □NO

Has your child held any jobs outside the home? □YES □NO If so, please explain:

_____

Describe your child's strengths:

_____

_____

Is there anything else you would like me to know about your child?

_____

_____

_____

Section 4
PRENATAL MEDICAL HISTORY

Were there any significant problems during the pregnancy? ☐YES ☐NO If so, specify:

_____

_____

How much alcohol was consumed during the pregnancy? _____

What medications and/or recreational drugs were used during the pregnancy?

_____

Length of:

Pregnancy _____ Labor and Delivery _____

Type of delivery: _____

Medications used during labor and delivery: _____

Were there any complications in labor/delivery? If so, explain:

_____

_____

Section 5
NEONATAL MEDICAL HISTORY

Birth Weight: _____ Length: _____

Were there any significant problems for the child at birth or as a newborn?

_____

_____

Did mother and child go home together? ☐YES ☐NO

If adopted, date/location of legal adoption:

Date:_____ Location:_____

Section 6
MEDICAL HISTORY

Check any of the following health problems your child has had:

☐ Ear infections	☐ Rash or Skin Problems	☐ Meningitis
☐ Ear/Hearing Problems	☐ Asthma	☐ Pneumonia
☐ Anemia	☐ Lead Poisoning	☐ High Fever (Greater than103°F)
☐ Surgery*	☐ Serious Injury*	☐ Heart Problems
☐ Obesity	☐ Slow Weight Gain	☐ Eye/Vision Problems
☐ Kidney/Urinary Problems	☐ Seizures/Convulsions	☐ Hospitalizations*
☐ Bowel Problems	☐ Allergies*	☐ Became ill Post Inoculation

☐ **Other:_____**

***Explain**

_____

_____

_____

Medications used over several months/years specify:

Is your child allergic to any medications or substances? Please list:

Has your child ever had a psychological, psychiatric, educational, or neurological evaluation? If so, why, when and by whom?

Has your child ever been in psychotherapy or counseling before?
Please list all past and present mental health treatment:

Dates	Type of Treatment	Provider's Name	Location

Has your child ever been hospitalized for emotional or behavioral reasons? ☐YES ☐NO If so, explain:

Does/has your child receive(d) any of the following:
(Please indicate with whom and frequency of treatment)

- ☐**Speech therapy services:**
- ☐**Physical therapy services:**
- ☐**Occupational therapy services:**
- ☐**Vision therapy services:**
- ☐**Auditory training services:**

Section 7

DEVELOPMENTAL HISTORY

A. INFANCY (0 - 12 MONTHS)

Indicate any of the following problems, delays or difficulties your child had in the first year (Check all that apply):

☐Feeding	☐Sleeping	☐Breathing
☐Bowel/urinary habits	☐Intolerance of affection	☐Inability to be consoled
☐Crawling	☐Emotional responsiveness	☐Hearing
☐Colic	☐Sitting unassisted	☐Vision

☐Other:_____

B. TODDLERHOOD (12 - 36 MONTHS)

Indicate any of the following problems, delays or difficulties your child had between 12 - 36 months of age (Check all that apply):

☐Feeding self	☐First words	☐Simple word combinations
☐Walking unassisted	☐Entertaining self	☐Self-destructive behavior
☐Stranger anxiety	☐Over activity	☐Thumb sucking
☐Using sentences	☐Toilet training	☐Rocking
☐Sleeping alone	☐Severe tantrums	

☐Other:_____

C. CHILDHOOD (3 - 11 YEARS)

Indicate any of the following problems, delays or difficulties your child had between the ages of 3 - 11 (Check all that apply):

☐Impulsive	☐Aggressive	☐Self-destructive habits
☐Shy	☐Temper tantrums	☐Short attention span
☐Nervous/fearful	☐Completing tasks/chores	☐Obeying adults at school
☐Motor coordination	☐Bowel/urinary habits	☐Reading skills
☐Writing skills	☐Math skills	☐Throwing things
☐Academic failure	☐Cooperating in groups	☐Easily frustrated
☐Anxious/nervous	☐Sleep problems	☐Cruelty to animals
☐Destroying property	☐Fire setting	☐Prolonged sadness/irritability
☐Low self-esteem	☐Extreme/unusual fears	☐School Refusal

☐Other:_____

D. ADOLESCENCE (12 - 18 YEARS)

Indicate any of the following problems, delays or difficulties your child had between the ages of 12 - 18 (Check all that apply):

☐Truancy	☐Delinquency	☐"Gang" membership
☐Social isolation	☐Aggression	☐Impulsivity
☐Lying	☐Sexually active	☐Pregnant
☐Temper outbursts	☐Fighting	☐Prolonged sadness/irritability
☐Bulimia/Anorexia	☐Legal problems	☐Destruction of property
☐Uses tobacco	☐Low self-esteem	☐Self-abusive behaviors
☐Binge eating	☐Suicidal (threats & attempts)	☐Running away
☐Academic failure	☐Drug or alcohol use	☐Difficulty sleeping
☐Cutting	☐Stealing	

☐Other:_____

Section 8

FAMILY MEDICAL/SOCIAL HISTORY

Please provide me with information for all biological, step- and adopted members of your child's immediate family:

Name_____ Occupation_____ AGE_____ ☐Living ☐Deceased
Role _____ ☐Bio ☐Step ☐Adopted Highest level education: ☐HS ☐BS ☐MS ☐PhD ☐JD ☐MD

Name_____ Occupation_____ AGE_____ ☐Living ☐Deceased
Role _____ ☐Bio ☐Step ☐Adopted Highest level education: ☐HS ☐BS ☐MS ☐PhD ☐JD ☐MD

Name________________________________ Occupation_____________________________________ AGE________________ ☐Living ☐Deceased
Role ________________________________ ☐Bio ☐Step ☐Adopted Highest level education: ☐HS ☐BS ☐MS ☐PhD ☐JD ☐MD

Name________________________________ Occupation_____________________________________ AGE________________ ☐Living ☐Deceased
Role ________________________________ ☐Bio ☐Step ☐Adopted Highest level education: ☐HS ☐BS ☐MS ☐PhD ☐JD ☐MD

Name________________________________ Occupation_____________________________________ AGE________________ ☐Living ☐Deceased
Role ________________________________ ☐Bio ☐Step ☐Adopted Highest level education: ☐HS ☐BS ☐MS ☐PhD ☐JD ☐MD

Name________________________________ Occupation_____________________________________ AGE________________ ☐Living ☐Deceased
Role ________________________________ ☐Bio ☐Step ☐Adopted Highest level education: ☐HS ☐BS ☐MS ☐PhD ☐JD ☐MD

Name________________________________ Occupation_____________________________________ AGE________________ ☐Living ☐Deceased
Role ________________________________ ☐Bio ☐Step ☐Adopted Highest level education: ☐HS ☐BS ☐MS ☐PhD ☐JD ☐MD

Consider all of your child's biological/step/adopted *siblings, parents, and grandparents* and list any past or currently significant:

A. Medical problems:

____

____

____

B. Mental illness (e.g. depression, anxiety, chemical dependency, psychiatric hospitalizations, abuse, ADHD):

____

____

____

C. Learning difficulties:

____

____

D. Legal problems:

____

____

E. Financial problems:

____

____

SECTION 9

Is there anything else you would like me to know or understand about your child?