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CHILD AND ADOLESCENT INVENTORY

Today's Date: _____ Referral Source: _____

PERSONAL INFORMATION

Child's Name: _____ Date: _____

Gender: _____ Height: _____ Weight: _____

FAMILY INFORMATION

Parents' Names: _____

Address: _____

Home Phone: _____

Bus Phone: _____

Cell Phone: _____

Years at Current Address: _____

Please complete following information for family members LIVING IN patient's home:

Name	Age	Sex	Relationship to Child	Education	Occupation
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please complete information for family members LIVING OUTSIDE patient's home:

Name	Age	Sex	Relationship to Child	Education	Occupation
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is your child:

Adopted? _____
Step Child? _____
Foster Child? _____

Are the parents:

Separated? Y / N How long _____
Divorced? Y / N How long _____
Deceased? Y / N How long _____
Remarried? Y / N How long _____

What languages are spoken in the child's home? _____

What is the primary language spoken at home? _____

Does any member of your family have a past or present history of chronic illness? Y / N

If yes, describe: _____

Is there a history of genetic disorders in the family? Y / N If yes, describe:

Has any family member had a language or speech problem? Y / N If yes, describe:

Has any family member had a history of hearing loss? Y / N If yes, describe: _____

Has any family member experienced any emotional problems? Y / N If yes, describe:

Has any family member experienced any major changes or stressful events in the recent past? Y / N If yes, describe:

Prenatal and Neonatal History

Has the child's mother ever had any miscarriages? Y / N If yes, describe: _____

Were there any complications in the pregnancies (other than patient)? Y / N If yes, describe: _____

Mother's age at patient's birth: _____

Check items that apply to mother during pregnancy:

_____ High Blood Pressure	_____ Anemia	_____ Excessive Sleepiness	_____ Tension
_____ Excessive Swelling	_____ Dizziness	_____ Xray Exposure	_____ Drug Use
_____ Rh Incompatibility	_____ Illness	_____ Morning Sickness	_____ Headaches
_____ Fainting Spells	_____ Smoked	_____ On Medication	_____ Bleeding

If you checked medication, drug use or illness, please describe in detail: _____

Was labor induced? Y / N Length of Pregnancy: _____

Length of Labor: _____ Birth Type: ___Regular ___Breech ___Cesarean

Were forceps used during delivery? Y / N

Was mother medicated during delivery? Y / N If yes, type: _____

Infant Birth Weight: _____ Was infant jaundiced at birth? Y / N

Put under heat lighting? Y / N Number of days infant in hospital: _____

Medical History

Name of Pediatrician: _____

Has your child had:

_____ Tubes inserted	_____ Measles	_____ Mumps
_____ Frequent Dizziness	_____ Excessive Colds	_____ Chicken Pox
_____ Allergies	_____ Frequent Fevers	_____ Draining Ear
_____ Frequent Ear Aches	_____ Diabetes	_____ Meningitis
_____ Severe Infections	_____ Pressure in Ear	_____ Loss of Hearing
_____ Heavy Medication	_____ Fainting	_____ Head Injury
_____ Asthma		

Does your child suffer from any neurological, genetic or other chronic illness or condition? Y / N If yes, describe: _____

Has your child ever been hospitalized? Y / N If yes, describe: _____

Has your child's vision ever been tested? Y / N If yes, when: _____

Results: _____

Has your child's hearing ever been tested? Y / N If yes, when: _____

Results: _____

How is your child's current health? _____

Recent medications (prescription and OTC): _____

Developmental History

At what age did your child:

_____ Say 3-6 different words	_____ Sit alone
_____ Combine words	_____ Dress self
_____ Stop drooling	_____ Crawl
_____ Sleep through the night	_____ Walk alone
_____ Toilet train (day)	_____ Say first word
_____ Toilet train (night)	_____ Babble

Check the items which apply to your child's infant behavior:

- | | | |
|--|---|--|
| <input type="checkbox"/> Frequently smiled | <input type="checkbox"/> Easy to soothe | <input type="checkbox"/> Frequently cried |
| <input type="checkbox"/> Difficult to soothe | <input type="checkbox"/> Cried when wet | <input type="checkbox"/> Enjoyed being held |
| <input type="checkbox"/> Cried when hungry | <input type="checkbox"/> Enjoyed being rocked | <input type="checkbox"/> Difficulty with novelty |
| <input type="checkbox"/> Adapted easily to novelty | | |

Did your child have difficulty with:

- Sucking Swallowing Chewing Sleeping Eating solids

As a toddler, was (is) your child:

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Talkative | <input type="checkbox"/> Quiet |
| <input type="checkbox"/> Curious | <input type="checkbox"/> Distractible | <input type="checkbox"/> Angry |
| <input type="checkbox"/> Daring | <input type="checkbox"/> Fearless | <input type="checkbox"/> Overactive |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Affectionate | <input type="checkbox"/> Difficult to discipline |
| <input type="checkbox"/> Compliant | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Friendly |

Child's Education

Name of School: _____

Type of School: Public Private Other Grade _____

Teacher Name: _____ Counselor Name: _____

In what school situations or subjects does your child perform best?

In what school situations or subjects does your child perform worst?

What grades does your child receive? _____

How does the school characterize your child's behavior? _____

Is your child's academic performance consistent? Y / N Explain: _____

Has your child's school performance changed? Y / N If yes, how? _____

Has your child ever been enrolled in any special education program? Y / N If yes,

Describe name and type of program: _____

Has your child ever received any kind of special services outside of school? Y / N If yes, type and date: _____

List previous schools attended (include nursery and daycare):

Name	Dates
_____	From ___/___/___ To ___/___/___
_____	From ___/___/___ To ___/___/___
_____	From ___/___/___ To ___/___/___
_____	From ___/___/___ To ___/___/___
_____	From ___/___/___ To ___/___/___

Has your child repeated any grades? Y / N Which grades: _____

Has your child ever been on academic probation? Y / N When: _____

Suspensions: _____ Expulsions: _____

Social and Interpersonal

Where does your child play most often? Home _____ Outdoors _____ Other _____

What type of leisure time activities does your child enjoy? _____

Is most of your child's time spent: Playing alone ___ Playing with siblings ___
Playing with adults ___ Playing with peers ___

On the average, how much television does your child watch each day? _____

What kinds of programs does your child like to watch? _____

What was your child's first experience in a play group situation? _____

When interacting with peers, might your child be described as:

Shy Assertive Aggressive Friendly
 Withdrawn Disinterested Enthusiastic Follower Leader

Does your child currently belong to any organized clubs/groups? Y / N If yes, describe:

Give a brief description of your child's relationship with:

Mother: _____

Father: _____

Sister(s): _____

Brother(s): _____

Pet(s): _____

What do you feel are your child's most positive behavioral characteristics?

What behaviors concern you?

When your child misbehaves, how do you respond? How does s/he respond in turn?

Presenting Problems

What do you feel is the major problem? _____

What does your spouse feel is the problem? _____

What does the school believe to be the problem? _____

In what situation(s) is the problem most apparent? _____

In what situation(s) is the problem least apparent? _____

When did the problem first become apparent? _____
