6832 Convent Boulevard Sylvania, OH 43560 419.882.4529

SOPHIA CENTER, INC.

Biographical Information Form - Child

Date: _____ Client I.D. #: _____(For office use only) e-mail_____

Client's full name _____ Nickname? _____

Mother's Name_____ Father's Name_____

Address_____ Telephone #_____

Client's Birth Date: _____/_____/_____ Client's Age: _____ ☐ Male ☐ Female

Date of Clinic Visit: _____/_____/_____

School_____ Grade_____ ☐ Retained in school? Grade Retained_____

Why?_____

Parent (or other responsible adult) completing this form: _____

Residential Parent and Phone # (In cases of divorce) _____

Parenting Arrangements (In case of Divorce)?_____

FAMILY INFORMATION (Please list names of everyone who lives in the current household with the child)

Name	Age	Relationship to Client	Highest Grade of School Completed (or current grade)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Was this child adopted? No_____ Yes_____ If so, please provide details of the adoption including age of child, reason for the adoption, country or origin, anything known about biological parent(s), etc.

_____

_____

Parent's Marital Status (check all that apply)

Mother:
- Currently married to child's father
- Never married to child's father
- Previously married to child's father
- Currently married to someone other than child's father
- Never Married
- Divorced/Date_____ Separated/Date _____ Widowed/Date _____
- Other/Date _____

Father:
- Currently married to child's mother
- Never married to child's mother
- Previously married to child's mother
- Currently married to someone other than child's mother
- Never married
- Divorced/Date _____ Separated/Date _____ Widowed/Date_____
- Other/Date _____

Parent's Employment:

Mother's job/profession: _____ Hours worked weekly in this activity: _____

Father's job/profession: _____ Hours worked weekly in this activity: _____

What are the PRESENTING problems for which the child is being evaluated?

_____

_____

_____

HISTORY OF CURRENT PROBLEMS

The current problems developed when the child was approximately age _____.

At that age, the following difficulties were noted (please list briefly):

1.

2.

3.

Please indicate any events occurring around that time that you believe may be related to the problems noted above:

_____

_____

_____

_____

_____

_____

Please review the following list of common behavioral/emotional problems. Indicate the extent to which each symptom describes YOUR child.

0 = This does not apply to my child to any significant degree
1 = This does apply to my child to a moderate degree, at least some of the time
2 = This clearly applies to my child and often causes significant problems for the child and for those around him
3 = I don't know the answer to this question

0 1 2 3

☐ ☐ ☐ ☐ Persistent worry about future events
☐ ☐ ☐ ☐ Overly concerned about past behaviors
☐ ☐ ☐ ☐ Preoccupied about competence
☐ ☐ ☐ ☐ Frequently complains about headaches/stomachaches
☐ ☐ ☐ ☐ Easily embarrassed
☐ ☐ ☐ ☐ Unusually tense
☐ ☐ ☐ ☐ Perfectionistic
☐ ☐ ☐ ☐ Disturbed sleep
☐ ☐ ☐ ☐ Fearful of performing in social situations
☐ ☐ ☐ ☐ Extremely shy
☐ ☐ ☐ ☐ Excessive fears
☐ ☐ ☐ ☐ Emotional reactions to separation from parent(s)
☐ ☐ ☐ ☐ Clinging behaviors
☐ ☐ ☐ ☐ Reluctance to sleep away from home
☐ ☐ ☐ ☐ Refuses to go to school
☐ ☐ ☐ ☐ Repetitive thoughts
☐ ☐ ☐ ☐ Refuses to speak in most social situations
☐ ☐ ☐ ☐ Ritualistic Behaviors (things they must do over and over the same way)

☐ ☐ ☐ ☐ Loses temper easily
☐ ☐ ☐ ☐ Argues with adults
☐ ☐ ☐ ☐ Refuses to comply with adult requests
☐ ☐ ☐ ☐ Blames others
☐ ☐ ☐ ☐ Vindictive

☐ ☐ ☐ ☐ Often angry and resentful
☐ ☐ ☐ ☐ Uses obscenities
☐ ☐ ☐ ☐ Purposely engages in behaviors to annoy others
☐ ☐ ☐ ☐ Violent towards people or property
☐ ☐ ☐ ☐ Cruelty to animals

☐ ☐ ☐ ☐ Defecates in inappropriate places
☐ ☐ ☐ ☐ Repeated voiding of urine during waking/sleeping

☐ ☐ ☐ ☐ Frightening dreams
☐ ☐ ☐ ☐ Sleep walks
☐ ☐ ☐ ☐ Vocalizes strange noises
☐ ☐ ☐ ☐ Vocalizes obscenities w/o provocation
☐ ☐ ☐ ☐ Imitates movements/words of others
☐ ☐ ☐ ☐ Tics

☐ ☐ ☐ ☐ Irritability
☐ ☐ ☐ ☐ Unusually sad
☐ ☐ ☐ ☐ Weight loss
☐ ☐ ☐ ☐ Weight gain

☐ ☐ ☐ ☐ Uses weapons during confrontations
☐ ☐ ☐ ☐ Steals
☐ ☐ ☐ ☐ Plays with fire/sets fires
☐ ☐ ☐ ☐ Persistently lies
☐ ☐ ☐ ☐ Runs away from home
☐ ☐ ☐ ☐ Persistently truant from school
☐ ☐ ☐ ☐ Lacks remorse for actions

0 1 2 3

☐ ☐ ☐ ☐ Easily distracted
☐ ☐ ☐ ☐ Makes careless errors
☐ ☐ ☐ ☐ Does not listen
☐ ☐ ☐ ☐ Disorganized
☐ ☐ ☐ ☐ Fidgets excessively
☐ ☐ ☐ ☐ Forgetful
☐ ☐ ☐ ☐ Does not follow directions
☐ ☐ ☐ ☐ Loses things
☐ ☐ ☐ ☐ Loud
☐ ☐ ☐ ☐ Interruptive
☐ ☐ ☐ ☐ Talks incessantly
☐ ☐ ☐ ☐ Unable to remain in seat
☐ ☐ ☐ ☐ Does not wait to turn in activities
☐ ☐ ☐ ☐ Accident prone
☐ ☐ ☐ ☐ Bossy

☐ ☐ ☐ ☐ Persistently eats non-food substances
☐ ☐ ☐ ☐ Intense fear of being fat

☐ ☐ ☐ ☐ Fails to maintain minimum body weight for height/age
☐ ☐ ☐ ☐ Self-induced vomiting
☐ ☐ ☐ ☐ Uses laxatives
☐ ☐ ☐ ☐ Deprives self of food
☐ ☐ ☐ ☐ Exercises excessively
☐ ☐ ☐ ☐ Preoccupied with body image
☐ ☐ ☐ ☐ Engages in recurrent binge eating
☐ ☐ ☐ ☐ Abuses substances (alcohol/drugs) What?_____

☐ ☐ ☐ ☐ No facial expression
☐ ☐ ☐ ☐ Does not initiate social interactions

☐ ☐ ☐ ☐ Tired
☐ ☐ ☐ ☐ Excessive sleep
☐ ☐ ☐ ☐ Avoidance of people or situations
☐ ☐ ☐ ☐ Hopeless
☐ ☐ ☐ ☐ Helpless
☐ ☐ ☐ ☐ Preoccupied with physical health
☐ ☐ ☐ ☐ Withdrawn and isolated
☐ ☐ ☐ ☐ Changes in personal hygiene
☐ ☐ ☐ ☐ Decline in school performance
☐ ☐ ☐ ☐ Talks of suicide
☐ ☐ ☐ ☐ Self-injurious behaviors
☐ ☐ ☐ ☐ Suicide attempts

☐ ☐ ☐ ☐ Mood swings
☐ ☐ ☐ ☐ Giddy mood
☐ ☐ ☐ ☐ Excess high risk/pleasure seeking behaviors
☐ ☐ ☐ ☐ Rapid speech
☐ ☐ ☐ ☐ Physically overactive
☐ ☐ ☐ ☐ Thinks he/she can do anything
☐ ☐ ☐ ☐ Severe rage episodes

☐ ☐ ☐ ☐ Has experienced traumatic/threatening event Identify_____
☐ ☐ ☐ ☐ Distressing themes expressed in play
☐ ☐ ☐ ☐ Dreams about traumatic event
☐ ☐ ☐ ☐ Shows distress in situations resembling traumatic event

☐ ☐ ☐ ☐ Exposes to one or more significant stressful events in past three months Identify_____
☐ ☐ ☐ ☐ Significant impairment in functioning since exposure
☐ ☐ ☐ ☐ Long-term tendency to over react to stressful situations

0 1 2 3

☐ ☐ ☐ ☐ Avoids situations that may prompt memory of event
☐ ☐ ☐ ☐ Inability to give or receive affection
☐ ☐ ☐ ☐ Easily alarmed
☐ ☐ ☐ ☐ Loss of recently acquired developmental skills

Please complete for ages 11 years and older:

Y N N/A

☐ ☐ ☐ Is there **current** substance abuse for alcohol, drug or tobacco?

Substance use/abuse or suspected abuse (circle all that apply):

alcohol marijuana cocaine heroin/opiates

tranquilizers hallucinogens, LSD PCP, "dust" "ecstasy" others: _____

Are there any problems not already mentioned?_____

_____

PAST PSYCHIATRIC HISTORY OF CHILD

List other psychologist(s)/counselors and approximate dates seen_____

_____

_____

PAST MEDICAL HISTORY OF CHILD

Name of Primary Care Physician: _____

Address_____

Telephone_____

When did the child most recently see his primary care physician? _____

Previous hospitalizations, surgery or major illnesses:

Dates of treatment/illness	**Nature of medical problem**	**Outcome of condition/treatment**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the child had head injuries or high fevers? If so, please describe. _____

_____

_____

_____

Past Medications _____

_____

Current Medications: **Dose Level of Medication(s)**

_____ _____

_____ _____

_____ _____

Allergies to Medication(s)

Medication to which child is allergic: _____

Description of allergic reaction: _____

Other allergies (e.g., specific food allergies, ragweed, cats, etc.): _____

Child's Immunization History

Are required immunizations up to date? ☐ Yes ☐ No

DEVELOPMENTAL AND PERINATAL HISTORY:

# of pregnancies prior to this child: _____

# of live births prior to this child: _____

# of miscarriages/stillbirths prior to this child: _____

Pregnancy

Y	N	N/A	
☐	☐	☐	Full term (=40 weeks)?
☐	☐	☐	Medications for the mother? If yes, specify:
☐	☐	☐	Bleeding/Spotting?
☐	☐	☐	Persistent vomiting?

Y	N	N/A	
☐	☐	☐	Eclampsia/pre-eclampsia, high blood pressure, swelling, urine protein?
☐	☐	☐	Gestational diabetes?
☐	☐	☐	Drugs or other toxic substances to which mother was exposed? What were they?_____
☐	☐	☐	Other illnesses?
☐	☐	☐	Maternal weight gain: _____pounds

Labor and Delivery

Y	N	N/A	
☐	☐	☐	Vaginal Delivery
☐	☐	☐	C-Section, emergency?
☐	☐	☐	C-section, planned or repeat?
☐	☐	☐	Forceps used?
☐	☐	☐	Meconium stain (fetal poo-poo)
☐	☐	☐	Breech presentation?
☐	☐	☐	Fetal bradycardia (slow heart rate)

Infant's condition at birth_____-

Birthweight of child: _____pounds _____ounces

First Year of Life

Y	N	N/A	
☐	☐	☐	Bottle fed?
☐	☐	☐	Breast fed?
☐	☐	☐	Slept well?
☐	☐	☐	Fretful?
☐	☐	☐	Colicky?
☐	☐	☐	Did your child struggle against you—touching, holding, hugging, etc?
☐	☐	☐	Did your child avoid looking at you?
☐	☐	☐	Any major health issues during child's first year of life? If yes, what were they_____

_____

Milestones

Age at walking unassisted (motor development) _____

Age baby spoke first words (language development) _____

Age child started using full sentences_____

Age at which child started reading_____

Age at which child could use the toilet consistently_____

Social Development

Does your child play well with other children? Describe_____

Does your child seem emotionally detached from other children/adults?_____

Special interests/hobbies_____

ACADEMIC HISTORY **(Please list schools attended, beginning with the most recent)**

Name of School(s)	Dates/grades attended
_____	_____
_____	_____
_____	_____
_____	_____

Y	N	N/A	
☐	☐	☐	Previous Psychological Assessments for Developmental or Learning Problems?

Type?_____

When_____

Does your child receive special educational services? ☐ Yes ☐ No If Yes, please explain_____

_____

Is your child on an IEP?_____

Is your child gifted?_____

FAMILY HISTORY

Family Stressors (check any that apply):

- ☐ Marital conflicts
- ☐ Parent/Child conflicts
- ☐ Financial problems
- ☐ Recent deaths
- ☐ Physical illness (Medical problems)
- ☐ Frequent moves
- ☐ Drug/alcohol abuse by parents
- ☐ Sexual/physical abuse
- ☐ Other_____

LEGAL HISTORY OF CHILD (Please describe any legal issues in which your child has been involved.)

_____

_____

FAMILY PSYCHIATRIC HISTORY

Please indicate the presence in biological relatives of any psychiatric problem, such as depression, suicide, alcoholism, drug abuse, anxiety, panic attacks, manic-depressive (bipolar) illness, schizophrenia, mental retardation, autism, learning disability, hyperactivity, attention deficit disorder, childhood behavior problems, school or academic problems, narcolepsy, obsessive compulsive disorder, etc.

Please provide details about problem(s) here:

Y	N	N/A	
☐	☐	☐	Child's father _____
☐	☐	☐	Father's parents, brothers, sisters_____
☐	☐	☐	Child's mother _____
☐	☐	☐	Mother's parents, brothers, sisters _____
☐	☐	☐	Child's brothers and sisters _____
☐	☐	☐	Other biological relatives _____

Family Circumstances: Please provide any information about the family that you feel would be important to understand the child's development and current problems: