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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:

____ Frequently smiled ____ Easy to soothe ____ Frequently cried
____ Difficult to soothe ____ Cried when wet ____ Enjoyed being held
____ Cried when hungry ____ Enjoyed being rocked ____ Difficulty with novelty
____ Adapted easily to novelty

Did your child have difficulty with:

____ Sucking ____ Swallowing ____ Chewing ____ Sleeping ____ Eating solids

As a toddler, was (is) your child:

____ Independent ____ Talkative ____ Quiet
____ Curious ____ Distractible ____ Angry
____ Daring ____ Fearless ____ Overactive
____ Stubborn ____ Affectionate ____ Difficult to discipline
____ Compliant ____ Aggressive ____ 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? _____

_____