SUBURBAN BEHAVIORAL HEALTH SERVICES

SBHS
1S443 Summit Ave, Suite # 305
Oakbrook Terrace, IL 60181
Phone (630) 613-9800
Fax (630) 613-9865

Adolescent Development History

(For Children 12 years -17 years old)

Today's Date: 07/12/2017

Patient's Full Name	Date of Birth	Age

Full Name of the Person/Guardian completing this form	Signature	Relationship to Patient

Describe the problem(s) your child is having and when they started:

Pregnancy and Birth History:

What was your child's birth weight? _____ lbs. _____ Oz. ☐ Unknown

Was the delivery normal? Yes
If No, please specify _____

Was there any problem during pregnancy? No
If Yes, please specify _____

Was alcohol, drugs or any medications used during pregnancy? No
If Yes, please specify _____

Did either parent smoke during the pregnancy? No
If Yes, who smoked _____

Did the birth mother experience any physical or emotional problems during pregnancy? No
If Yes, please specify _____

Today's Date: 07/12/2017

Did baby experience any problems immediately after birth? No

If Yes, please specify _____

Has the child ever been hospitalized? No

If Yes, please specify _____

Is there any history of physical, sexual or emotional abuse? No

If Yes, please specify _____

At what age did your child do the following? (Parenthesis areas reflect Normal Development)

- ☐ Held head up (3 to 4 months)
- ☐ Rolled over (6 months)
- ☐ Crawled (6-10 months)
- ☐ Walked by self (12 months)
- ☐ Talked in sentence (30 to 36 months)
- ☐ Established toilet training (2 ½ to 4 years)
- ☐ Smiled (6 months)
- ☐ Sat alone (6 to 10 months)
- ☐ Pulled up (6 to 10 months)
- ☐ Talked in single words (18 to 24 months)
- ☐ Fed self (2 years)
- ☐ Rode a bike (6 years)

Social History:

Does your child makes friends easily? How does she/he get along with others?

What hobbies/interests does your child have (Include extracurricular activities)?

What are your child's strengths? What does she/he believe are strengths?

What are you child's difficulties? What does she/he believe are areas that need improvement?

Today's Date: 07/12/2017

Treatment History:

What school and grade is your child currently attending?

School Name _____ Grade _____

Is your child expected to pass this school year? No

Has your child ever failed a class or been held back for academic reasons? No

If Yes, please specify _____

Is your child currently seeing another psychiatrist, psychologist, social worker or counselor? No

If Yes, name of the treatment provider _____ Phone number _____

May we contact your child's treatment provider in order to coordinate care? No

If Yes, please sign release of information _____

If No please provide the reason of it _____

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