Anne Huebner & Associates
Phone: 262-786-9184
17100 W. North Ave., Ste. 100 Brookfield, WI 53005
Fax: 262-786-1906

ADOLESCENT DEVELOPMENTAL HISTORY (AGES 12-17/18)

Adolescent's Name: _____Gender: ☐ Male ☐ Female

Date of Birth: _____

Grade: _____ School:_____

Form completed by: _____

Relationship to adolescent: _____ Date: _____

PRESENTING CONCERNS

In your opinion, what led to this referral? Check all that apply

- ☐ Developmental delays
- ☐ Symptoms of anxiety
- ☐ Thinking problems
- ☐ Adjustment to parents' divorce
- ☐ Suspected abuse
- ☐ Suspected autism spectrum disorder
- ☐ Reading difficulties
- ☐ Behavior problems at home
- ☐ Refusal to attend school
- ☐ Other: _____
- ☐ Symptoms of depression
- ☐ Suicidal thoughts
- ☐ Difficulties with parents
- ☐ Problems with peers/poor social skills
- ☐ Refusal to attend school
- ☐ Fears/Anxiety
- ☐ Academic difficulties
- ☐ Behavior problems at school
- ☐ Substance Use/Abuse

How severe is/are the problem(s)? _____

_____

When were these problems first noted? _____

What is most concerning about the adolescent? _____

_____

Any additional information? _____

PREGNANCY and BIRTH

At the time of the adolescent's birth, what was the mother's age?_____ Father's age_____

Did mother receive prenatal care? ☐None ☐ Yes - throughout entire pregnancy ☐ Some _____

Check any of the following complications that occurred during the pregnancy:

☐Measles ☐German measles ☐Excessive Swelling ☐Anemia ☐Toxemia ☐Vaginal bleeding ☐Flu

☐Rh Incompatibility ☐Abnormal weight gain ☐High Blood Pressure ☐Excessive Vomiting

☐Emotional Problems _____

☐ Stressors (describe) _____

☐ Other not listed: _____

Pregnancy Cont.			**If yes…**
Injury to Mother:	☐ Yes	☐ No	Describe:_____
Hospitalization during pregnancy	☐ Yes	☐ No	Reason:_____
X-ray during pregnancy:	☐ Yes	☐ No	What month:_____
Medications used during pregnancy:	☐ Yes	☐ No	Name:_____
Alcohol or other drugs used prior to discovering pregnancy	☐ Yes	☐ No	When was pregnancy discovered? _____
Alcohol used during pregnancy:	☐ Yes	☐ No	Frequency:_____
Cigarettes used during pregnancy:	☐ Yes	☐ No	Frequency:_____
Other drugs used during pregnancy:	☐ Yes	☐ No	Type and frequency:_____

Length of pregnancy:_____ **Length of labor:**_____

Length of stay in hospital? Mother:_____ Child:_____

Birth weight: _____lbs _____oz **Apgar Score(s)** _____

Child's condition at birth:_____

Mother's condition at birth:_____

Check any of the following complications that occurred during or after birth:

- ☐ Forceps used
- ☐ Labor induced
- ☐ Infection
- ☐ Cord wrapped around neck
- ☐ Need supplemental oxygen
- ☐ Incubator
- ☐ Other _____
- ☐ Breech birth
- ☐ Caesarean delivery
- ☐ Seizures
- ☐ Jaundice
- ☐ Ventilator
- ☐ Problems with heart
- ☐ Problems with bones
- ☐ Blood transfusion
- ☐ Cyanosis
- ☐ NICU stay

DEVELOPMENTAL INFORMATION

Were developmental milestones completed on time (e.g., walking, talking, toilet training, speech or motor problems)?
___Y ___N If not completed on time, please explain: _____
_____

Is the adolescent? ☐**right handed** ☐**left handed** ☐**both**
Has the adolescent lost any skills (e.g., with regard to motor or speech skills)?

MEDICAL INFORMATION

Please check any of the following that the adolescent has had, and indicate the age?

	Age		Age
☐ Measles	_____	☐ German Measles	_____
☐ Mumps	_____	☐ Rheumatic Fever	_____
☐ Chicken Pox	_____	☐ Diphtheria	_____
☐ Tuberculosis	_____	☐ Meningitis	_____
☐ Whooping Cough	_____	☐ Encephalitis	_____
☐ Anemia	_____	☐ Seizures	_____
☐ Diabetes	_____	☐ Asthma	_____
☐ Rashes	_____	☐ Hay fever	_____
☐ Eczema	_____	☐ Seasonal allergies	_____
☐ Broken Bones	_____	☐ Pneumonia	_____
☐ Food allergies	_____	☐ Frequent headaches	_____
☐ Stomach aches	_____	☐ Other	_____
☐ Head Trauma			

Hearing:			**Vision:**		
Frequent ear infections	☐ Yes	☐ No	Vision problems	☐ Yes	☐ No
Tubes	☐ Yes	☐ No	Wears Glasses	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No			
Sensitive to certain sounds	☐ Yes	☐ No	Sensitive to certain lights or colors	☐ Yes	☐ No
Has the adolescent's hearing been evaluated?	☐ Yes	☐ No	Has the adolescent's vision been evaluated?	☐ Yes	☐ No

Hearing Evaluation Results : _____ Date: _____
Who tested hearing? (e.g., doctor, school, ECI) _____
Vision Evaluation Results: _____ Date: _____
Who tested vision? (e.g., doctor, school, ECI) _____

Sleep

Past	Present	
☐	☐	No sleep difficulties
☐	☐	Trouble falling asleep
☐	☐	Wakes up frequently at night
☐	☐	Still tired after a good night's sleep
☐	☐	Does not get enough sleep
☐	☐	Restless in bed
☐	☐	Nightmares
☐	☐	Night terrors
☐	☐	Refuses to go to bed
☐	☐	Change in sleep pattern
☐	☐	Sleeps too much
☐	☐	Wakes up too early
☐	☐	Falls asleep in school
☐	☐	Refuses to get up in the morning
☐	☐	Snores
☐	☐	Sleeps with parent or sibling
☐	☐	Sleep Apnea (appears to hold breath when asleep)

Appetite

Past	Present	
☐	☐	Normal increase in weight/height
☐	☐	Unusual weight gain _____lbs.
☐	☐	Unusual weight loss _____lbs.
☐	☐	Concerns about height/growth?
☐	☐	Increase in appetite
☐	☐	Decrease in appetite
☐	☐	Gags on certain textures
☐	☐	Purposely throws up after eating
☐	☐	Food allergies _____
☐	☐	Eats excessively
☐	☐	Picky eater
☐	☐	Will only eat certain types of food_____
☐	☐	On a special diet_____

Please indicate if the adolescent has ever had any of the following? If so describe.

- ☐ Seizure disorder _____
- ☐ Accident prone _____
- ☐ Bites nails or cuticles _____
- ☐ Sucks thumb _____
- ☐ Grinds teeth _____
- ☐ Has tics or twitches _____
- ☐ Bangs head _____
- ☐ Rocks back and forth _____
- ☐ Fever over 104 degrees _____
- ☐ Head injury _____
- ☐ Loss of consciousness _____

Current medications, indicate dosage:

_____ _____

_____ _____

Previous medications (Indicate when s/he stopped taking them):

_____ _____

_____ _____

Primary care physician: _____

Has the adolescent ever had a psychological or psychiatric exam? ☐ **Yes** ☐ **No**

Provider's name: _____
When: _____
Reason: _____

Has the adolescent ever had psychological counseling or therapy? ☐ **Yes** ☐ **No**

Therapist's name: _____
When: _____
Reason: _____

Has the adolescent ever had a neurological exam? ☐ **Yes** ☐ **No**

Neurologist's name: _____
When: _____
Reason: _____

Describe any medical or mental health hospitalizations and/or surgeries with dates:

_____

_____

Please indicate if any <u>family members</u> have had the following and specify that person's relationship to the adolescent.

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Migraine headaches _____
- ☐ Physical handicap _____
- ☐ Tuberculosis _____
- ☐ Huntington's chorea _____
- ☐ Muscular dystrophy _____
- ☐ Sickle cell anemia _____
- ☐ Tay-sachs disease _____
- ☐ Tourette's syndrome _____
- ☐ Cerebral palsy _____
- ☐ Birth defect _____
- ☐ Alcohol abuse _____
- ☐ Drug abuse _____
- ☐ Behavior disorder _____
- ☐ Emotional problems _____
- ☐ Mental illness _____
- ☐ Mental retardation _____
- ☐ Nervousness _____
- ☐ Reading problems _____
- ☐ Learning disability _____
- ☐ Speech problem _____
- ☐ Language problem _____
- ☐ Severe head injury _____
- ☐ Other _____

TEMPERAMENT, BEHAVIOR, AND RELATIONSHIPS:

Which traits best describe the adolescent now?

- ☐ Calm
- ☐ Tired
- ☐ Affectionate
- ☐ Withholds affection
- ☐ Tearful
- ☐ Active
- ☐ Cries a lot
- ☐ Difficult
- ☐ Happy
- ☐ Overreacts
- ☐ Sociable
- ☐ Irritable/Cranky
- ☐ Distracted
- ☐ Sad
- ☐ Moody
- ☐ Withdrawn
- ☐ Playful
- ☐ Funny
- ☐ Impulsive
- ☐ Worries
- ☐ Feels lonely often
- ☐ Self-conscious
- ☐ Even tempered
- ☐ Lacks self control
- ☐ Gets mad easily
- ☐ Hides Feelings
- ☐ Difficult to calm
- ☐ Easily upset by changes in routine
- ☐ Easily overstimulated
- ☐ Other _____

What is the best thing about the adolescent? _____

What makes the adolescent angry?_____

Does the adolescent have any specific fears? ☐ **Yes** ☐ **No**
Describe:_____

Does the adolescent engage in any ritualistic or compulsive behavior? ☐ **Yes** ☐ **No**
Describe:_____

Has the adolescent engaged in any of the following behaviors?

- ☐ None
- ☐ Stolen without confrontation
- ☐ Lies often
- ☐ Hits other children
- ☐ Destruction of property
- ☐ Used/tried to use a weapon in a fight
- ☐ Stolen with confrontation
- ☐ Tries to Run away
- ☐ Deliberate fire-setting
- ☐ Hits adults
- ☐ Cruel to animals
- ☐ Often initiates physical fights
- ☐ Drugs or alcohol

What time does the adolescent usually go to bed on school nights? _____

Has the adolescent ever experienced any emotional, verbal, physical, or sexual abuse? _____

_____

What is most difficult about raising the adolescent? _____

Who is mainly in charge of discipline at home?_____

Do all caregivers agree on discipline?_____

Which of the following methods of discipline are used at home?

- ☐ Verbal Reprimands
- ☐ Rewards
- ☐ Ignore behavior
- ☐ Time out
- ☐ Physical punishment
- ☐ Discuss behavior
- ☐ Loss of privileges
- ☐ Give in to child
- ☐ Earn privileges
- ☐ Other _____

What discipline techniques are effective? _____

What discipline techniques are ineffective? _____

Has the adolescent experienced any of the following stressful events during the past year? Check all that apply

- ☐ Parents separated or divorced
- ☐ Parent changed jobs
- ☐ Family financial problems
- ☐ Other:_____
- ☐ Family accident or illness
- ☐ Changed schools
- ☐ Chronic health problems
- ☐ Death in the family
- ☐ Family moved

How many moves has the adolescent had to make within the last three years? _____

How does the adolescent relate to others? Check all that apply

☐ Has many close friends ☐ Has several close friends ☐ Has few close friends
☐ Has no close friends ☐ Makes friends easily ☐ A leader
☐ A follower ☐ Fights with playmates ☐ Prefers to play alone
☐ Prefers younger children ☐ Prefers older children ☐ Prefers adults
☐ Interacts well with siblings ☐ Difficulty with siblings ☐ Teased by others
☐ Teases others ☐ Feels rejected by peer group ☐ Is jealous of others
☐ Has friends who get in trouble ☐ Wants friends, but doesn't know how to make or keep them
☐ Feels lonely

How does the adolescent spend his/her free/play time? _____
_____
_____

FAMILY INFORMATION

Mother's Name:	**Father's Name:**
Occupation:	Occupation:
Employer:	Employer:
Ethnicity:	Ethnicity:
Highest Grade Completed:	Highest Grade Completed:

Please list all persons residing with the family and their relationship to the adolescent.

Name	Age	Gender	Relationship to child

If parents are divorced, separated, or not with the adolescent, who has custody? _____
What are the adolescent's placement arrangements? _____
If adolescent is not living with a parent, does s/he see this parent __Y__N
If so, how often? _____

Primary language spoken by the adolescent:_____

Primary language spoken at home: _____

ACADEMIC INFORMATION

List the schools the adolescent has attended: _____

Has the adolescent been in a bi-lingual classroom? ☐ No ☐ Yes. If yes – how long? _____

Which of the following did the adolescent attend? Check all that apply
☐ Infant day care ☐ Kindergarten
☐ Preschool ☐ None

Which of the following describe the adolescent's experiences now? Check all that apply
☐ Good grades ☐ Frequently absent
☐ Failing grades ☐ Tested for special education
☐ Average grades ☐ Tested for the gifted program
☐ Cooperative student ☐ Tutored
☐ Suspended, _____number of times ☐ Retained, what year_____
☐ Expelled, _____number of times ☐ Loses temper easily

What are the adolescent's current subject strengths?

- ☐ None
- ☐ Spelling
- ☐ Music
- ☐ Math
- ☐ Social Studies
- ☐ Athletics/PE
- ☐ History
- ☐ English
- ☐ Reading
- ☐ Art
- ☐ Science
- ☐ Other

What are the adolescent's current subject weaknesses?

- ☐ None
- ☐ Spelling
- ☐ Music
- ☐ Math
- ☐ Social Studies
- ☐ Athletics/PE
- ☐ History
- ☐ English
- ☐ Reading
- ☐ Art
- ☐ Science
- ☐ Other

Which are the adolescent's current skill strengths? Check all that apply

- ☐ None
- ☐ Concentration
- ☐ Organization
- ☐ Memorization
- ☐ Papers and reports
- ☐ Handwriting
- ☐ Checking work carefully
- ☐ Paying attention
- ☐ Getting assignments done
- ☐ Vocabulary/expression
- ☐ Understanding concepts
- ☐ Pleasing the teacher
- ☐ Reading speed
- ☐ Reading comprehension
- ☐ Working hard
- ☐ Completing homework
- ☐ Intelligence
- ☐ Behaving correctly
- ☐ Spelling
- ☐ Taking tests
- ☐ Turning in homework
- ☐ Test preparation
- ☐ Other

Which are the adolescent's current skill weaknesses? Check all that apply

- ☐ None
- ☐ Concentration
- ☐ Organization
- ☐ Memorization
- ☐ Papers and reports
- ☐ Handwriting
- ☐ Checking work carefully
- ☐ Paying attention
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- ☐ Intelligence
- ☐ Behaving correctly
- ☐ Spelling
- ☐ Taking tests
- ☐ Turning in homework
- ☐ Test preparation
- ☐ Other

Does the adolescent work outside of school? __Y __N If yes, where? _____

What are some primary responsibilities of the adolescent at their job? _____

_____

How many hours does the adolescent work each week? _____

GOALS

What goals would you/the adolescent like to accomplish in treatment?

1) _____

_____

2) _____

_____

3) _____

_____

4) _____

_____

5) _____

_____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Psychologist/Therapist Signature: _____ Date: _____

ADOLESCENT SYMPTOM CHECKLIST

Please read each symptom/behavior listed and indicate how often the adolescent has experienced it (frequency), and how long the adolescent has experienced it (duration).

Symptoms	Rarely	3-4 times month	3-6 times week	Daily	How Long
1. Anxious, tense mood, difficulty controlling worry	**0**	**1**	**2**	**3**	
2. Panic attacks (intense and sudden fear)	**0**	**1**	**2**	**3**	
3. Anxiety and/or avoidance in social situations	**0**	**1**	**2**	**3**	
4. Specific intense fears (e.g. driving, needles, etc.) *Specify:*	**0**	**1**	**2**	**3**	
5. Obsessions and/or compulsions (excessive concern with cleanliness, orderliness, checking things, etc.).	**0**	**1**	**2**	**3**	
6. Having urges to break or smash thins	**0**	**1**	**2**	**3**	
7. Difficulty concentrating and focusing on tasks	**0**	**1**	**2**	**3**	
8. Fatigue, feeling tired even with good sleep	**0**	**1**	**2**	**3**	
9. Feeling worthless, low self-esteem	**0**	**1**	**2**	**3**	
10. Decreased interest in previously enjoyed activities	**0**	**1**	**2**	**3**	
11. Feeling hopeless, things will never change	**0**	**1**	**2**	**3**	
12. Thoughts of suicide or death	**0**	**1**	**2**	**3**	
14. Preoccupation with sexual thoughts/activities	**0**	**1**	**2**	**3**	
15. Irritable mood, snapping at others, easily angered	**0**	**1**	**2**	**3**	
16. Episodes of rage, really “losing” it	**0**	**1**	**2**	**3**	
17. Unexplained “up” mood, restless, lots of energy	**0**	**1**	**2**	**3**	
18. Impulsive behavior that the adolescent wouldn’t “normally” do	**0**	**1**	**2**	**3**	
19. Racing thoughts that the adolescent cannot control	**0**	**1**	**2**	**3**	
20. Seeing/hearing things that are not real	**0**	**1**	**2**	**3**	
21. Feeling nothing or “numb” emotionally	**0**	**1**	**2**	**3**	
22. Recurrent, intrusive thoughts or images	**0**	**1**	**2**	**3**	
23. Easily startled, overly “watchful”	**0**	**1**	**2**	**3**	
24. Feeling you are watched or talked about by others	**0**	**1**	**2**	**3**	
25. Difficulty trusting others and feeling safe	**0**	**1**	**2**	**3**	
26. Persistent fears about health problems despite doctors finding nothing wrong	**0**	**1**	**2**	**3**	
27. Occupational concerns: job dissatisfaction, problems with employer or co-workers (if applicable)	**0**	**1**	**2**	**3**	
28. Relationship problems with friends/family	**0**	**1**	**2**	**3**	
29. Use of caffeine (coffee, cola, tea, Mt. Dew, etc.)	**0**	**1**	**2**	**3**	
30. Smoking cigarettes	**0**	**1**	**2**	**3**	
31. Drinking alcohol (beer, wine, liquor)	**0**	**1**	**2**	**3**	
32. Use of prescription drugs in non-prescribed ways	**0**	**1**	**2**	**3**	
33. Use of marijuana, cocaine, or other street drugs	**0**	**1**	**2**	**3**	