Thelma F. Lynch, RN, PH.D

Psychologist

Children, Adolescents, Adults

1806 Town Plaza Ct.
Winter Springs, FL 32708

407-850-8875
Fax: 407-695-3674

Child/Adolescent Psychosocial

Identifying Information:

Name of Child: ______ Sex: ☐ M ☐ F Birth Date: ______

Place of Birth: ______ Age: ______ Religion (optional): ______

Address: number and street: ______

city: ______ state: ______ zip: ______ Telephone: ______

Education (grade): ______ Current School: ______

Referral Source: ______

I give permission to Dr. Thelma Lynch to contact my child's physician, teacher, etc. regarding treatment issues, symptoms, behaviors or other information necessary for the treatment of my child.

Parent Signature ______________________________ Date: ______

CHIEF COMPLAINT:
Presenting Problems: (check all that apply)

☐ Very unhappy
☐ Irritable
☐ Temper Outburst
☐ Withdrawn
☐ Daydreaming
☐ Fearful
☐ Clumsy
☐ Overactive
☐ Slow
☐ Short attention span
☐ Distractible
☐ Lacks initiative
☐ Undependable
☐ Peer Conflict
☐ Phobic
☐ Impulsive
☐ Stubborn
☐ Disobedient
☐ Infantile
☐ Mean to others
☐ Destructive
☐ Trouble with the law
☐ Running Away
☐ Self-mutilating
☐ Head banging
☐ Rocking
☐ Shy
☐ Strange behavior
☐ Strange thoughts
☐ Fire setting
☐ Stealing
☐ Lying
☐ Sexual trouble
☐ School performance
☐ Truancy
☐ Bed wetting
☐ Soiled pants
☐ Eating problems
☐ Sleeping problems
☐ Sickly
☐ Drug use
☐ Alcohol use
☐ Suicide talk

Explain:

How long have these problems occurred? (number of weeks, months, years)

What happened to make you seek help at this time?

Problems perceived to be: ☐ very serious ☐ serious ☐ not serious

What are your expectations of your child?

What changes would you like to see in your child?

PSYCHOSOCIAL HISTORY:
CURRENT FAMILY SITUATION:

Mother – Relationship to child ☐ natural parent ☐ relative ☐ step-parent ☐ adoptive parent

Occupation Education

Birthplace Birth date Age

Father – Relationship to child ☐ natural parent ☐ relative ☐ step-parent ☐ adoptive parent

Occupation Education

Birthplace Birth date Age

Marital History of Parents:

Natural Parent: ☐ married when age age
☐ separated when
☐ divorced when
☐ deceased M or F
Step-parents ☐ married when

If child is adopted:

Adoption source:

Reason and circumstances:

Age when child first in home: Date of legal adoption:

What has the child been told?

LIVING ARANGEMENTS:

Number of moves in the child's life [ ]

Places	Dates

Present Home ☐ renting ☐ buying
☐ house ☐ apartment

Does the child share a room with anyone else? ☐ Yes ☐ No

If yes, with whom?

If no, how long has he/she had own room?

Was the child ever placed, boarded, or lived away from the family? ☐ Yes ☐ No

Explain:

What are the major family stresses at the present time, if any?

What are the sources of family income?

BROTHERS and SISTERS: (indicate if step-brothers or step-sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at home (yes or no)	Use of drugs or alcohol (yes of no)	Treated for drug abuse (yes or no)

List all other extended family members by their relation to the patient who have drug and/or alcohol problems (legal or illegal), history of depression, self-destructive behavior, or legal problems.

1.
2.
3.
4.
5.

Others living in the home (and their relationship):

1.
2.

HEALTH OF FAMILY MEMBERS: (excluding patient)

Name	Relationship to child	Type of illness	When occurred	Length of illness

Does or did any member of the child's family have any problems with:

☐ reading ☐ spelling ☐ math ☐ speech

(if yes, please explain.)

Is there any history in the child's family of:

☐ mental retardation ☐ epilepsy ☐ birth defects ☐ schizophrenia

(if yes, please explain.)

CHILD HEALTH INFORMATION:

Note all health problems the child has had or has now.

	AGE		AGE
☐ High fevers		☐ Dental Problems	
☐ Pneumonia		☐ Weight Problems	
☐ Flu		☐ Allergies	
☐ Encephalitis		☐ Skin Problems	
☐ Meningitis		☐ Asthma	
☐ Convulsions		☐ Headaches	
☐ Unconsciousness		☐ Stomach Problems	
☐ Concussions		☐ Accident Prone	
☐ Head injury		☐ Anemia	
☐ Fainting		☐ High or Low Blood Press.	
☐ Dizziness		☐ Sinus Problems	
☐ Tonsils Out		☐ Heart Problems	
☐ Vision Problems		☐ Hyperactivity	
☐ Hearing Problems		☐ Other Illnesses, etc	
☐ Earaches			

Has the child ever been hospitalized? ☐Yes ☐No

If yes, please explain.

Age	How Long	Reason

Has the child ever been seen by a medical specialist? ☐Yes ☐No

If yes, please explain.

Age	How Long	Reason

Has child ever taken, or is taking any prescribed medications? ☐Yes ☐No

If yes, please explain.

Age	How Long	Reason

DEVELOPMENTAL HISTORY:

Prenatal - Child wanted? ☐Yes ☐No Planned for? ☐Yes ☐No

Normal pregnancy? ☐Yes ☐No

If mother was ill or upset during pregnancy, explain:

Length of pregnancy:

Paternal support and acceptance: (explain)

BIRTH:

Length of active labor: ____ hrs. ☐Easy ☐Difficult

If premature, how early:

If overdue, how late:

Birth weight: ____ lbs. ____ oz.

Type of delivery: ☐spontaneous ☐cesarean ☐with instruments

☐head first ☐breach

Was it necessary to give the infant oxygen? ☐Yes ☐No If yes, how long: [ ]

Did infant require blood transfusions? ☐Yes ☐No

Did infant require X-ray? ☐Yes ☐No

Physical condition of infant at birth:

(If yes explain)

anorexia	☐Yes	☐No
trauma	☐Yes	☐No
other complications	☐Yes	☐No

Did mother abuse alcohol/drugs during pregnancy? ☐Yes ☐No

NEWBORN PERIOD

			How Long
irritability	☐Yes	☐No	
vomiting	☐Yes	☐No	
difficulty breathing	☐Yes	☐No	
difficulty sleeping	☐Yes	☐No	
convulsions/twitching	☐Yes	☐No	
colic	☐Yes	☐No	
normal weight gain	☐Yes	☐No	
was child breast fed	☐Yes	☐No	

DEVELOPMENTAL MILESTIONES:
Age at which child:

sat up:	
crawled:	
walked:	
spoke single words:	
spoke sentences:	
bladder trained:	
bowel trained:	
weaned:	

Describe the manner in which toilet training was accomplished.

EARLY SOCIAL DEVELOPMENT:

Relationship to siblings and peers: ☐ individual play ☐ group play ☐ competitive ☐ cooperative ☐ leadership role ☐ a follower

Describe special habits, fears, or idiosyncrasies of the child:

EDUCATIONAL HISTORY:

	Name of School	City/State	Dates attended: from	to	Grades completed at this school
preschool					
elementary					
junior high					
high school					

Types of classes: ☐ regular ☐ learning disability ☐ continuation ☐ emotionally handicapped ☐ opportunity ☐ other

Did child skip a grade? ☐ Yes ☐ No Repeat a grade? ☐ Yes ☐ No

(If yes, when and how many years appropriate grade level at present time?)

Did child have any specific learning difficulties? ☐ Yes ☐ No

Has child ever had a tutor or other special help with school work? ☐ Yes ☐ No

Does child attend school on a regular basis? ☐ Yes ☐ No

Does child appear motivated for school? ☐ Yes ☐ No

Has child ever been suspended or expelled? ☐ Yes ☐ No

ACADEMIC PERFORMANCE:

Highest grade on last report card? Lowest grade on last report card?

Favorite subject?

Least favorite subject?

Does child participate in extracurricular activities? ☐ Yes ☐ No (explain)

In school, how many friends does child have: ☐ a lot ☐ a few ☐ none

What are child's educational aspirations? ☐ quit school
☐ graduate from high school
☐ go to college

Has child had special testing in school? (If yes, what were the results?)
Psychological ☐ Yes ☐ No Vocational ☐ Yes ☐ No

List child's special interest, hobbies, skills:

Has the child ever had difficulty with the police? ☐ Yes ☐ No (if yes, explain)

Has child ever appeared in juvenile court? ☐ Yes ☐ No (if yes, explain)

Has child ever been on probation? ☐ Yes ☐ No

From	To	Reason	Probation Officer

Has child ever been employed? ☐ Yes ☐ No

Job	Employer	How long

ADDITIONAL COMMENTS:

Therapist____Date________________