

Pediatric Professional Association
Psychology
Family Information Form
Ages 13-18 years

General Background

Adolescent's name _____ Nickname _____
Age _____ Birthdate _____ Gender _____
Address _____ Home Phone _____
City, State _____ Zip Code _____
Father's Name _____ Age _____ Work/Cell Phone _____
Mother's Name _____ Age _____ Work/Cell Phone _____

Relationship to Child: (Circle 1)

Marital Status: Unmarried _____
Father: Natural _____ Adoptive _____ Foster _____ Step _____ Married _____ Divorced _____
Mother: Natural _____ Adoptive _____ Foster _____ Step _____ Married _____ Divorced _____

Other Children:	Name	Age	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who referred you? _____ Name of Child's Doctor _____
Reason for Referral: _____

Parent Information

Education – Highest Grade Completed Mother _____ Father _____
Employment- Job Position:
Father _____ Hours a week: _____
Mother _____ Hours a week: _____
Describe any additional job circumstances that may be important _____

Do you think the family is under a financial strain? Yes _____ No _____

Describe a typical weekday and weekend for parents and adolescent:

Has either parent ever received counseling or psychotherapy? _____ Yes _____ No
If yes, describe problem, therapist, any medication, current status and dates:

How would you describe your marriage during the past six months? (circle one)

Very Good Good Fair Bad Very Bad

How would you describe your marriage during the last month? (circle one)

Very Good Good Fair Bad Very Bad

Do you and your spouse agree on the 2 previous questions? _____ Yes _____ No

If not, how would your spouse rate these questions? _____

Siblings not applicable _____

Please list names, gender, and ages of siblings

Have any of your other children ever received counseling or psychotherapy? ___ Yes ___ No

If yes, describe problem, therapist, any medication, current status and dates:

Do any of your other children have an emotional or behavioral problem that concerns you?

Do any of your other children have physical health problems that interfere with normal functioning?

Growth and Development

Adolescent's general infant development: ____ Poor ____ Fair ____ Good

Current weight _____ Current height _____

Does this child have a physical health problem that interferes with typical functioning?

Is your adolescent on any medication at the present time? ____ Yes ____ No

What kind and who prescribed? _____ Why? _____

How long has he/she been on the medication _____

Does it affect his/her behavior? ____ How? _____

Has your child ever received counseling or psychotherapy? ____ Yes ____ No

If yes, describe problem, therapist, any medication, current status and dates:

How are your adolescent's relationships with the following? (circle one for each)

Father: Very Good Good Fair Bad Very Bad

Mother: Very Good Good Fair Bad Very Bad

Siblings: Very Good Good Fair Bad Very Bad

Sleep Habits

What time is s/he usually in bed? _____

What time is s/he usually asleep? _____

Does s/he usually wake up in the night? _____

What does s/he do when s/he awakens? _____

Where does s/he fall asleep? _____

Where does s/he wake up? _____

Do you and your adolescent agree about what their sleep habits should be? _____

Meals

How many times a week do you get to eat dinner with your adolescent? _____

Does s/he help with meal preparation? _____

Do you argue about any aspect of his/her eating habits? _____

Discipline

Who ordinarily disciplines your adolescent? _____
How is your child disciplined? Yell ___ Hit ___ Reasoning ___ Take away privileges ___
Send to room ___ Ground ___ other _____
How often do you need to use discipline? _____
Have your methods of discipline been effective? _____
Do parents agree on discipline? _____

School

What school, if any, does your child attend? _____
Address _____

Teacher's name _____ Principal's name _____
Grade _____ progress: (circle one) Poor Fair Good Very Good
Phone: _____ Hours in Attendance: _____

Have you had extra conferences with teacher or school authorities for behavior or learning problems? _____
What do they suggest is needed to help your child? _____
Do you agree with teacher, or what are your ideas about what is needed?

Work

Does your adolescent have a job? ___ Yes ___ No
If yes, where and how many hours per week? _____
Do you and your adolescent agree on their choice of workplace and hours they are working?

Does your adolescent have a curfew? ___ Yes ___ No
If yes, what time is the curfew and does s/he follow it? _____

Which of the following have been or are now problems with your adolescent?

	Yes	No	Sometimes		Yes	No	Sometimes
Defiant	___	___	___	Lying	___	___	___
Motivation	___	___	___	Soiling	___	___	___
Bad Temper	___	___	___	Bedwetting	___	___	___
Anxious	___	___	___	Cruel to animals	___	___	___
Substance abuse	___	___	___	Peer relations	___	___	___
Sexuality	___	___	___	Habit	___	___	___
Easily upset	___	___	___	Too shy	___	___	___
Stealing	___	___	___	Brother/Sisters	___	___	___
Nightmares	___	___	___	Panic	___	___	___
Destructive	___	___	___	Cruel to others	___	___	___
Hyperactive	___	___	___	Depression	___	___	___