

**AFFILIATES IN CLINICAL SERVICES, PC**  
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**CHILD BIOGRAPHICAL FORM**

**Instructions:** To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strict confidence within legal limits. If certain questions don't apply to the child, leave blank.

- 1) Information supplied by: \_\_\_\_\_ Relationship: \_\_\_\_\_  
2) Individual holding legal custody of patient: \_\_\_\_\_

**Personal History**

- 3) Child's Name: \_\_\_\_\_  
4) Age: \_\_\_\_\_  
5) School Grade Level: \_\_\_\_\_  
6) Gender: \_\_\_M \_\_\_F  
7) Weight: \_\_\_\_\_  
8) Height: \_\_\_\_\_  
9) Eye color: \_\_\_\_\_  
10) Hair color: \_\_\_\_\_  
11) Race: \_\_\_\_\_  
12) Has the child been involved in previous counseling? Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, please describe treatment and results: \_\_\_\_\_  
\_\_\_\_\_  
13) Why is the child coming to counseling?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
14) How long has this problem persisted (from 13)?: \_\_\_\_\_  
15) Under what conditions do the problems usually get worse?: \_\_\_\_\_  
\_\_\_\_\_  
16) Under what conditions are the problems usually improved?: \_\_\_\_\_  
\_\_\_\_\_

**Medical History**

- 17) Primary Care Physician (PCP):  
Provider's name: \_\_\_\_\_  
Address/Phone Number: \_\_\_\_\_  
18) List present physical issues: (e.g., high blood pressure, headaches, dizziness, etc.) \_\_\_\_\_  
\_\_\_\_\_  
19) On average how many hours of sleep does the child get daily? \_\_\_\_\_  
20) Do they have trouble falling asleep at night? Yes \_\_\_ No \_\_\_ If Yes, describe \_\_\_\_\_  
\_\_\_\_\_

21) Current medications/dosages, including over the counter, child is taking?

Medication	Prescribed by	Dose	Purpose

22) Describe the child's appetite (during the past week): \_\_\_\_\_ poor \_\_\_\_\_ average \_\_\_\_\_ large

**Family History**

23) Mother's age: \_\_\_\_\_ If deceased, how old was the child when she passed away?: \_\_\_\_\_

24) Father's age: \_\_\_\_\_ If deceased, how old was the child when he passed away?: \_\_\_\_\_

25) If parents are separated or divorced, how old was the child then?: \_\_\_\_\_

26) Number of brother(s) \_\_\_\_\_ Their ages \_\_\_\_\_

27) Number of sister(s) \_\_\_\_\_ Their ages \_\_\_\_\_

28) Child number \_\_\_\_\_ being in a family of \_\_\_\_\_ children.

29) Is the child adopted or raised with parents other than biological parents?: \_\_\_ Yes \_\_\_ No

30) Briefly describe the child's relationship with brothers and/or sisters:

Biological siblings: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Step and/or half siblings: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other: \_\_\_\_\_  
 \_\_\_\_\_

31) What is the family relationship between the child and his/her custodial parents?

Check all that apply:

- Single parent mother       Single parent father       Parents unmarried  
 Parents married, together       Parents divorced       Parents separated  
 With mother and stepfather       With father and stepmother  
 Child adopted       Other, describe \_\_\_\_\_

32) Is there a history or recent occurrence(s) of child abuse to this child? \_\_\_ Yes \_\_\_ No

If Yes, which type(s) of abuse? \_\_\_ Verbal \_\_\_ Physical \_\_\_ Sexual

Comments: \_\_\_\_\_  
 \_\_\_\_\_

33) Parents' occupations: Mother \_\_\_\_\_ Father \_\_\_\_\_

34) Briefly describe the style of parenting used in the household: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family Psychiatric History**

- |                    |                 |                    |
|--------------------|-----------------|--------------------|
| 35) Family Member: | Date/Diagnosis: | Treatment/Results: |
| _____              | _____           | _____              |
| _____              | _____           | _____              |
| _____              | _____           | _____              |

**Developmental History**

- 36) Briefly describe any problems in the child's mother's pregnancy and/or childbirth:
- \_\_\_\_\_
- \_\_\_\_\_

- 37) Please fill in when the following developmental milestones took place:

<u>Behavior</u>	<u>Age began</u>	<u>Comments</u>
Walking	_____	_____
Talking	_____	_____
Toilet trained	_____	_____

- 38) List any drugs used by mother or father at time of conception, or by mother during pregnancy:
- \_\_\_\_\_

- 39) Please rate your opinion of the child's development (compared to others the same age) in the following areas:

	Below Average	About Average	Above Average
Social	_____	_____	_____
Physical	_____	_____	_____
Language	_____	_____	_____
Intellectual	_____	_____	_____
Emotional	_____	_____	_____

For each type of development that you rated above as *below* average, please describe current areas of concern. Be specific.

\_\_\_\_\_

\_\_\_\_\_

- 40) What report card grades does the child usually receive? \_\_\_\_\_  
Have these changed lately? \_\_\_\_ Yes \_\_\_\_ No If Yes, how?: \_\_\_\_\_

- 41) Briefly describe the child's hobbies and interests: \_\_\_\_\_
- \_\_\_\_\_

- 42) Describe how the child is disciplined: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

- 43) For what reasons is the child disciplined? \_\_\_\_\_
- \_\_\_\_\_

### Behaviors of Concern

44) Please check how often the following behaviors occur. Those occurring FREQUENTLY or of special concern may be described on the next page.

- |   |                                |                                 |                                    |                                     |
|---|--------------------------------|---------------------------------|------------------------------------|-------------------------------------|
| 1) Loses temper easily                  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 2) Argues with adults                   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 3) Refuses adults' requests             | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 4) Deliberately annoys people           | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 5) Blames others for own mistakes       | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 6) Easily annoyed by others             | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 7) Angry/resentful                      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 8) Spiteful/vindictive                  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 9) Defiant                              | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 10) Bullies/teases others               | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 11) Initiates fights                    | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 12) Uses a weapon                       | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 13) Physically cruel to people          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 14) Physically cruel to animals         | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 15) Stealing                            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 16) Forced sexual activity              | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 17) Intentional arson                   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 18) Burglary                            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 19) "Cons" other people                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 20) Runs away from home                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 21) Truant at school                    | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 22) Doesn't pay attention to details    | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 23) Several careless mistakes           | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 24) Does not listen when spoken to      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 25) Doesn't finish chores/homework      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 26) Difficulty organizing tasks         | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 27) Loses things                        | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 28) Easily distracted                   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 29) Forgetful in daily activities       | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 30) Fidgety/squirmy                     | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 31) Difficulty remaining seated         | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 32) Runs/climbs around excessively      | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 33) Difficulty playing quietly          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 34) Hyperactive                         | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 35) Difficulty awaiting turn            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 36) Interrupts others                   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 37) Problems pronouncing words          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 38) Poor grades in school               | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 39) Expelled from school                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 40) Drug abuse (including prescription) | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 41) Alcohol consumption                 | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 42) Depression                          | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 43) Shy/avoidant/withdrawn              | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 44) Suicidal threats/attempts           | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 45) Fatigued                            | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 46) Anxious/nervous                     | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 47) Excessive worrying                  | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 48) Sleep disturbance                   | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 49) Panic attacks                       | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 50) Mood shifts                         | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 51) Caffeine consumption                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| 52) Nicotine/Tobacco use                | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |

