



SOPHIA CENTER

SOPHIA CENTER, INC.

BIOGRAPHICAL INFORMATION FORM – CHILD

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Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to your child or you are not comfortable answering them, leave them blank.

Today's Date: ____ / ____ / ____ Parent/Legal Guardian E-mail: _____

Who referred you? _____

Client's full name: _____

Preferred name: _____ Birth date: ____ / ____ / ____

Ethnic background: _____ Cultural preference: _____

Religious preference: _____

School: _____ Grade: _____

Grades repeated and why: _____

Parent/legal guardian completing this form: _____

Parent/legal guardian marital status: _____

Residential parent and phone # (In cases of divorce): _____

Parenting arrangements (In cases of divorce): _____

Parent/legal guardian employment: _____

Parent/legal guardian employment: _____

Was this child adopted? No Yes

If so, please provide details of the adoption including age of child, reason for the adoption, country or origin, anything known about biological parent(s), etc.

FAMILY INFORMATION

(Please list names of everyone who lives in the current household with the child.)

Name	Age	Relationship to Client	Highest Grade of School Completed (or current grade)

Family stressors (check all that apply):

- Family conflicts
- Parent/child conflicts
- Financial problems
- Partner conflicts
- Recent deaths
- Physical illness (Medical problems)
- Frequent moves
- Drug/alcohol abuse by parents/family members
- Trauma
- Other _____

Why did you want the child to be evaluated? List the behaviors you want to change.

Briefly describe your relationship with your current support system and your child's support system:

HISTORY OF CURRENT PROBLEMS

The current problems developed when the child was approximately age _____.

At that age, the following difficulties were noted (please list briefly):

Please indicate any events occurring around that time that you believe may be related to the problems noted above:

How many hours does your child sleep a day? _____

**How much time per day does your child spend on social media? _____
(e.g. Tic Tok, Instagram, Facebook, cell phone)**

How many hours per day does your child play video games or watching TV? _____

How are your child's eating habits?

Please review the following list of common behavioral/emotional problems. Indicate the extent to which each symptom describes YOUR child.

0 = This does not apply to my child to any significant degree

1 = This does apply to my child to a moderate degree, at least some of the time

2 = This clearly applies to my child and often causes significant problems for the child and for those around him

3 = I don't know the answer to this question

0	1	2	3	Problem
				Persistent worry about future events
				Overly concerned about past behaviors
				Preoccupied about competence
				Frequently complains about headaches/stomachaches
				Easily embarrassed
				Unusually tense
				Perfectionistic
				Disturbed sleep
				Fearful of performing in social situations
				Extremely shy
				Excessive fears
				Emotional reactions to separation from parent(s)
				Clinging behaviors
				Reluctance to sleep away from home
				Refuses to go to school
				Repetitive thoughts
				Refuses to speak in most social situations
				Ritualistic Behaviors (things they must do over and over the same way)

0	1	2	3	Problem
				Loses temper easily
				Argues with adults
				Refuses to comply with adult requests
				Blames others
				Vindictive
				Often angry and resentful
				Uses obscenities
				Purposely engages in behaviors to annoy others
				Violent towards people or property
				Cruelty to animals
				Defecates in inappropriate places
				Repeated voiding of urine during waking/sleeping
				Excessive masturbation
				Frightening dreams
				Sleepwalks
				Vocalizes strange noises
				Vocalizes obscenities w/o provocation
				Imitates movements/words of others
				Tics

0	1	2	3	Problem
				Irritability
				Unusually sad
				Weight loss
				Weight gain
				Uses weapons during confrontations
				Steals
				Plays with fire/sets fires
				Persistently lies
				Runs away from home
				Persistently truant from school
				Lacks remorse for actions
				Easily distracted
				Makes careless errors
				Does not listen
				Disorganized
				Fidgets excessively
				Forgetful
				Does not follow directions
				Loses things
				Loud

0	1	2	3	Problem
				Interruptive
				Talks incessantly
				Unable to remain in seat
				Does not wait to turn in activities
				Accident prone
				Bossy
				Persistently eats non-food substances
				Intense fear of being fat
				Fails to maintain minimum body weight for height/age
				Self-induced vomiting
				Uses laxatives
				Deprives self of food
				Exercises excessively
				Preoccupied with body image
				Engages in recurrent binge eating
				Abuses substances (alcohol/drugs)

0	1	2	3	Problem
				No facial expression
				Does not initiate social interactions
				Tired
				Excessive sleep
				Avoidance of people or situations
				Hopeless
				Helpless
				Preoccupied with physical health
				Withdrawn and isolated
				Changes in personal hygiene
				Decline in school performance
				Talks of suicide
				Self-injurious behaviors
				Suicide attempts
				Mood swings
				Giddy mood
				Excess high risk/pleasure seeking behaviors
				Rapid speech
				Physically overactive
				Thinks he/she can do anything
				Severe rage episodes

0	1	2	3	Problem
				Distressing themes expressed in play
				Dreams about traumatic event
				Shows distress in situations resembling traumatic event
				Significant impairment in functioning since exposure
				Long-term tendency to overreact to stressful situations
				Avoids situations that may prompt memory of event
				Inability to give or receive affection
				Easily alarmed
				Loss of recently acquired developmental skills

Substance use/abuse or suspected abuse (check all that apply):

- alcohol marijuana cocaine heroin/opiates
 tranquilizers hallucinogens, LSD. PCP, "dust" "ecstasy"
 others: _____

Has the child experienced traumatic/threatening events or been exposed to stressful events?

Are there any problems not already mentioned?

PAST PSYCHIATRIC HISTORY OF CHILD

List other psychologist(s)/counselors and approximate dates seen:

MEDICAL HISTORY OF CHILD

Name of Primary Care Physician:

Address: _____

Telephone: _____

When did the child most recently see his primary care physician?

Previous hospitalizations, surgery or major illnesses:

Date(s) of treatment/illness	Nature of medical problem	Outcome of condition/treatment

Past Medications:

Current Medications / Dose Levels of Medication(s):

Medication to which child is allergic:

Description of allergic reaction:

Other allergies (e.g., specific food allergies, ragweed, cats, etc.):

Child's Immunization History

Are required immunizations up to date? Yes No

DEVELOPMENTAL AND PERINATAL HISTORY:

Check here if unknown

of pregnancies prior to this child: _____

of live births prior to this child: _____

of miscarriages/stillbirths prior to this child: _____

<i>Pregnancy</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Full term (= 40 weeks)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Medications for the mother If yes, specify: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding/Spotting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Persistent vomiting
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eclampsia/pre-eclampsia, high blood pressure, swelling, urine protein
<input type="checkbox"/> Yes <input type="checkbox"/> No	Gestational diabetes
<input type="checkbox"/> Yes <input type="checkbox"/> No	Drugs or other toxic substances to which mother was exposed What were they: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other illnesses
<i>Labor and Delivery</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Delivery
<input type="checkbox"/> Yes <input type="checkbox"/> No	C-Section, emergency
<input type="checkbox"/> Yes <input type="checkbox"/> No	C-section, planned
<input type="checkbox"/> Yes <input type="checkbox"/> No	Forceps used
<input type="checkbox"/> Yes <input type="checkbox"/> No	Meconium stain (feces in amniotic fluid)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Breech presentation
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fetal bradycardia (slow heart rate)
Infant's condition at birth: _____	
Birthweight of child: _____ pounds _____ ounces	

<i>First Year of Life.</i> <input type="checkbox"/> Check here if unknown	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Eat well
<input type="checkbox"/> Yes <input type="checkbox"/> No	Slept well
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fretful
<input type="checkbox"/> Yes <input type="checkbox"/> No	Colicky
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did your child struggle against you (touching, holding, hugging, etc.)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did your child avoid looking at you
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any major health issues during child's first year of life If yes, what were they: _____ _____

Milestones

Check here if unknown

Age at walking unassisted (motor development): _____

Age baby spoke first words (language development): _____

Age child started using full sentences: _____

Age at which child started reading: _____

Age at which child could use the toilet consistently: _____

Social Development

Does your child play well with other children? Describe:

Does your child seem emotionally detached from other children/adults?

Special interests/hobbies:

ACADEMIC HISTORY

(Please list schools attended, beginning with the most recent)

Name of School(s)	Date(s)/Grade(s) attended

Retained in school? Yes No

Grade retained: _____ Reason: _____

List any difficulties at school:

Previous Psychological Assessments for Developmental or Learning Problems

Yes No N/A

Type:

When:

Does your child use 504/IEP? Yes No N/A

Does your child receive special educational services? Yes No N/A

Does your child participate in gifted programs at school? Yes No N/A

LEGAL HISTORY OF CHILD

(Please describe any legal issues in which your child has been involved.)

List their five greatest strengths:

1.

2.

3.

4.

5.

List your five greatest areas of concern:

1.

2.

3.

4.

5.

FAMILY PSYCHIATRIC HISTORY

Please indicate the presence in biological relatives of any psychiatric problem, such as depression, suicide, alcoholism, drug abuse, anxiety, panic attacks, bipolar disorder, schizophrenia, intellectual disabilities, autism spectrum disorder, learning disability, attention deficit hyperactivity disorder, childhood behavior problems, school or academic problems, narcolepsy, obsessive compulsive disorder, etc.

Please provide details about problem(s) here:

Child's father: Yes No N/A

Father's parents, brothers, sisters: Yes No N/A

Child's mother: Yes No N/A

Mother's parents, brothers, sisters: Yes No N/A

Child's brothers and sisters: Yes No N/A

Other biological relatives: Yes No N/A
