SOPHIA CENTER, INC.

BIOGRAPHICAL INFORMATION FORM – CHILD

5335 Silica Drive, Sylvania, OH 43560 Phone: 419.882.4529 Fax: 419.885.7612

sophiacenterinfo@sophia.center

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): ___________________________________

Other Parent Phone __________________________

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?

____

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 testing and approximate date(s) seen-please bring a copy to your first appointment:

____

____

____

____

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.):

____

<u>Child's Immunization History</u>

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: ______________

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

First Year of Life.	☐ Check here if unknown
☐ Yes ☐ No	Eat well
☐ Yes ☐ No	Slept well
☐ Yes ☐ No	Fretful
☐ Yes ☐ No	Colicky
☐ Yes ☐ No	Did your child struggle against you (touching, holding, hugging, etc.)
☐ Yes ☐ No	Did your child avoid looking at you
☐ Yes ☐ 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.)

____

____

____

____

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

____

____

<u>Family Circumstances</u>: Please provide any information about the family that you feel would be important to understand the child's development and current problems.

____

____

____

____

____

____

____

____

____

____

____

____