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Biographical Information Form – Child

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 _____

Ethnic background _____ Cultural preference _____

Birth Sex: _____ Gender Identity: _____

Religious preference _____

Parent/legal guardian completing this form _____

Parent/legal guardian marital status _____

Residential Parent and Phone # (In cases of divorce) _____

Parenting Arrangements (In case of Divorce) _____

Residential Parent and Phone # (In cases of divorce) _____

Other parent phone # _____

Parent/legal guardian Employmen _____

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)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Family Stressors (check any 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

- 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

- 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

0 1 2 3

- Frightening dreams
- Sleepwalks
- Vocalizes strange noises
- Vocalizes obscenities w/o provocation
- Imitates movements/words of others
- Tics
- Irritability
- Unusually sad
- Weight loss
- Weight gain
- Uses weapons during confrontations

0 1 2 3

- 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

- 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

0 1 2 3

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)

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

0 1 2 3

Rapid speech

Physically overactive

Thinks he/she can do anything

Severe rage episodes

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 date(s) seen

MEDICAL HISTORY OF CHILD

Name of Primary Care Physician _____

Address _____

–

Telephone _____

–

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

Previous hospitalizations, surgery or major illnesses:

Dates of treatment/illness	Nature of medical problem	Outcome of condition/treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medications

Current Medication(s):

Dose Level 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: _____

Pregnancy check here if unknown

Y N

- Full term (=40 weeks)?
- Medications for the mother? If yes, specify: _____
- Bleeding/Spotting?
- Persistent vomiting?

Y N

- Eclampsia/pre-eclampsia, high blood pressure, swelling, urine protein?
- Gestational diabetes?
- Drugs or other toxic substances to which biological mother was exposed? _____
- Other illnesses?

Labor and Delivery check here if unknown

Y N

- Vaginal Delivery
- C-Section, emergency?
- C-section, planned?
- Forceps used?
- Meconium stain (feces in amniotic fluid)
- Breech presentation?
- Fetal bradycardia (slow heart rate)

Infant's condition at birth _____

Birthweight of child: _____pounds _____ounces

First Year of Life check here if unknown

Y N

- Eat well?
- Slept well?
- Fretful?
- Colicky?
- Did your child struggle against you—touching, holding, hugging, etc?
- Did your child avoid looking at you?
- 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)

Dates/grades attended

Retained in school

Grade Retained _____ Reason _____

List any difficulties at school:

Y N

Previous Psychological Assessments for Developmental or Learning Problems

Type _____

When _____

—

- Does your child use 504/IEP?
- Does your child receive special educational services? _____
- Does your child participate in gifted programs at school? _____

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:

Y N N/A

Child's father

Father's parents, brothers, sisters

Child's mother

Mother's parents, brothers, sisters

Child's brothers and sisters

Other biological relatives

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