CHILD/ADOLESCENT MEDICAL/FAMILY HISTORY

(to be completed by parent)

Child's Name

_____

Parents' Name(s)

_____

DATE:_____

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CHILD/ADOLESCENT
MEDICAL/FAMILY HISTORY
(to be completed by parent)

Patient Information

Child's Name:_____

Date of Birth:_____ **Age**_____ **Sex** _____

Home Address _____

City_____**STATE**_____**ZIP CODE**_____

Home Phone_____ **Parent/Guardian Work Phone**_____**CELL**_____

Parent/Guardian Personal Email (Not shared or work mail)_____

Child's School:_____

Address:_____**Grade:**_____

Present home of child (please check in appropriate box)	Adult with whom child is living	Non-residential adults involved with child
Natural Mother		
Natural Father		
Stepmother		
Stepfather		
Adoptive Mother		
Adoptive Father		
Other (Specify)		

Source of referral _____

Address_____

Phone_____

Briefly state your concerns

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School History

1. **Please list schools attended—first current and then most recent—and include: the name of the school, the grades attended and the city where the school was located:**

SCHOOL	CITY	GRADES ATTENDED

2. **Has the child ever been in any type of special program, and if so, how long?**

	YES	NO	DURATION
Learning disabilities class			
Behavioral disorders class			
Resource room			
Private tutoring			
Other (please specify):			

3. **Has your child ever been?**

	Yes	No	When
Suspended from school			
Expelled from school			
Repeated a grade			

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Current Behavioral Concerns

Please indicate any behavioral concerns:

SECONDARY CONCERNS:

Are any of the following significant problems at the present time or in the past?	**YES**	**NO**
Steals		
Has run away from home overnight at least twice		
Often lies		
Sets fires		
Often truant		
Breaking and entering		
Cruel to animals		
Sexual activity		
Physical fights		
Bullying or being bullied		
If Yes, please comment briefly:		

Types of discipline you use with your child:	**Yes**	**No**
Verbal reprimands		
Time out (Isolation)		
Removal of privileges		
Rewards		
Physical punishment		
Give in to child		
Avoidance of child		

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Have any of the following stress events occurred within the past 12 months?	**Yes**	**No**
Parents divorced or separated	☐	☐
Family accident or illness	☐	☐
Death in the family	☐	☐
Parent changed or lost job	☐	☐
Changed schools	☐	☐
Family moved	☐	☐
Family financial problems	☐	☐
Other (please specify)	☐	☐
If Yes, please comment briefly:		

Social History

Please describe how your child gets along with siblings.

How easily does your child make friends?

How well does your child keep friendships?

Does your child primarily play—and/or spend time with children:

☐ **Own Age** ☐ **Older** ☐ **Younger**

Please describe any problems your child may have with peers.

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Interests and Accomplishments

What are your child's main hobbies and interests?

What are your child's areas of greatest accomplishments?

What does your child enjoy doing most?

What does your child dislike doing most?

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Developmental Factors

Pregnancy

Mother's age when child was born_____**Duration of pregnancy (weeks)**_____

Infection(s) Specify:_____

Toxemia_____ **Rh incompatibility**_____

Operation(s) Specify_____

Other illnesses Specify_____

Did you smoke during pregnancy?_____ **Number of cigarettes/day**_____

Illicit drug use during pregnancy (describe)_____

Alcohol consumption during pregnancy (describe)_____

Prescribed Medications taken during pregnancy_____

X-ray studies during pregnancy_____

Delivery

Type of delivery:

☐ Normal ☐ Breech ☐ Cesarean Birth weight :_____

Any complications and/or indications of fetal distress during delivery?

Infant injured during delivery? _____

Other:_____

Post-delivery Period

☐ **Jaundice** ☐ **Cyanosis (turned blue)** ☐ **Incubator care**

Infections? (specify):_____

Number of days infant was in hospital after delivery_____

Any health complications following birth?_____

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Medical History

Rate your child on the following:

	GOOD	AVERAGE	POOR	MOST RECENT EXAMINATION (Month/Year)
General health				
Hearing				
Vision				

Has your child had any chronic health problems (asthma, diabetes, heart condition, etc.)? Specify.

When was the onset of any chronic illness?_____

Has your child had any of the following illnesses:

Yes	No		Yes	No	
		Mumps			Encephalitis (Brain Infection)
		Chicken pox			Ear Infections
		Measles			Lead Poisoning
		Whooping Cough			Seizures, (Convulsion)
		Scarlet Fever			OTHER (Please Specify):
		Pneumonia			

Has your child had any accidents resulting in the following?

Yes	No		Yes	No	
		Broken bones			Stomach pumped (poisoning)
		Severe lacerations			Eye injury
		Head injury, coma, amnesia			Lost teeth
		Severe bruises			Sutures
		Broken bones			OTHER (Please Specify):

Has your child had surgery for any of the following?

YES	NO		YES	NO	
		Tonsillitis			Digestive disorder
		Adenoids			Urinary tract
		Hernia			Leg or arm
		Appendicitis			Burns
		Eye, ear, nose, throat			OTHER (Please Specify):

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Is there any suspicion or history of alcohol or drug use?

Is there any history of physical or sexual abuse?

Does the child have any problems sleeping?

Does the child have bladder or bowel control problems?

Does the child have any eating disorder symptoms?

1. List all medications your child currently takes.

NAME OF MEDICATION	DOSAGE AND FREQUENCY	NAME OF DOCTOR WHO PRESCRIBED MEDICATION	DOCTOR's PHONE NUMBER

2. List all over-the-counter medications (including vitamin supplements) your child currently takes.

		HOW OFTEN?	
NAME OF MEDICATION/SUPPLEMENT	DOSAGE TAKEN	ONCE A DAY	OTHER (SPECIFY FREQUENCY)

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Treatment History

Has the child ever had any of the following forms of psychological treatment?

Yes	No	Date/Duration	
☐	☐		**Individual psychotherapy**
☐	☐		**Group psychotherapy**
☐	☐		**Family therapy with child**
☐	☐		**Inpatient evaluation and treatment**
☐	☐		**Residential treatment (including drug and alcohol)**

List names/phone numbers of all other professionals consulted for any of the above treatments.

DOCTOR'S NAME	PHONE NUMBER	TREATMENT

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Family History

How long have you and the child's other caregiver been married?_____

Please indicate whether the child is:

☐ **biological** ☐ **adopted** ☐ **other (Please specify)**_____

Is the child from your 1st, 2nd, 3rd, etc. marriage?_____

Siblings					
	NAME	**BIOLOGICAL**	**ADOPTED**	**OTHER (Specify)**	**AGE**
1					
2					
3					
4					
5					
6					
7					
8					

Additional Remarks

Please use this space to include additional remarks about your child's needs and or difficulties.

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Paternal Relatives—Family History

CHILD'S	Father	Paternal GrandMother	Paternal GrandFather	Paternal Aunt	Paternal Uncle
Problems with aggressiveness, defiance, and oppositional behavior as a child					
Learning disabilities					
Mental retardation					
Psychosis or schizophrenia					
Depression for greater than two weeks					
Anxiety disorder that impaired judgment					
Tics or Tourette's					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests					
Physical abuse					
Sexual abuse					

Please comment briefly:

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Maternal Relatives—Family History

CHILD'S	Mother	Maternal GrandMother	Maternal GrandFather	Maternal Aunt	Maternal Uncle
Problems with aggressiveness, defiance, and oppositional behavior as a child					
Learning disabilities					
Mental retardation					
Psychosis or schizophrenia					
Depression for greater than two weeks					
Anxiety disorder that impaired judgment					
Tics or Tourette's					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests					
Physical abuse					
Sexual abuse					

Please comment briefly:

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Siblings—Family History

CHILD'S	Brother	Brother	Sister	Sister	
Problems with aggressiveness, defiance, and oppositional behavior as a child					
Problems with attention, activity, and impulse control as a child					
Learning disabilities					
Mental retardation					
Psychosis or schizophrenia					
Depression for greater than two weeks					
Anxiety disorder that impaired judgment					
Tics or Tourette's					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests					
Physical abuse					
Sexual abuse					

Please comment briefly: