Medical History Form - Child & Adolescent

Name: ______________________ Account Number: ___________________ Date: _________

Current School: _____________________

School Phone Number: _______________

Grade in School: ____________________

Father's Name: _____________________

Mother's Name: _____________________

Parent's Marital Status: Married ___
Separated ___
Divorced ___

Other children in home:

	Name	Age	Grade
1.	___________	______	________
2.	___________	______	________
3.	___________	______	________
4.	___________	______	________

Others Living in Home:

	Name	Age	Rela. to child
1.	_____________	____	_________
2.	_____________	____	_________
3.	_____________	____	_________

Referred by: _________________________

Name of Therapist: ____________________

Primary Care MD: _____________________.

List all Current Medications, Vitamins, Additives and Supplements:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

List any allergies your child has:

1. ______________________________
2. ______________________________
3. ______________________________

Did the biological Mother have pregnancy or delivery problems?

Did the child mother use any of the following during pregnancy?

Illegal drugs	Yes	No
Prescribed medications	Yes	No
Alcohol	Yes	No
Tobacco	Yes	No

What brings you here today?

When did the problems begin?

What interventions have you tried?

What impact have the problems had on the family?

Describe how the child functions in school:

How does your child get along with other children?

Has your child been treated for any psychological or emotional problems before now?

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Has the child repeated a grade? If yes, which one?

Has the child had psychological testing completed by the school?

Has the child had an Individual Education Plan (IEP)?

Did your child have any delays in learning to:

Crawl	Yes	No
Walk	Yes	No
Speak	Yes	No

Has your child used or tried:

Alcohol	Used	Tried
Tobacco	Used	Tried
Illegal Substances	Used	Tried

Medical issues (check those that apply)

Hearing:

- ❑ Chronic ear infections
- ❑ Surgery or tubes
- ❑ Hearing problem

Vision

- ❑ Eye or vision problems
- ❑ Lazy eye
- ❑ Uses prescription glasses or contacts

Neurological

- ❑ Head trauma
- ❑ Severe headaches
- ❑ Seizures
- ❑ Encephalitis
- ❑ Meningitis
- ❑ Black outs
- ❑ Chronic dizziness
- ❑ Poor coordination

Medical Issues - continued

Other

- ❑ Shortness of breath or asthma
- ❑ Digestive problems
- ❑ Hepatitis
- ❑ Diabetes
- ❑ Broken bone(s)
- ❑ Muscle problems
- ❑ Hormone system
- ❑ Sleep
- ❑ Appetite
- ❑ Other (list) ___________________________

Is your child sexually active?

Have there been any recent stresses in the family? If yes, please explain.

Family Psychiatric History

Circle F for family and/or C for child.

Depression	F	C
Manic Depression	F	C
Post Partum Depression	F	C
Suicide	F	C
Anxiety	F	C
Agoraphobia	F	C
Other phobias	F	C
Obsessive compulsive disorder	F	C
Other stress disorder	F	C
Anorexia	F	C
Bulimia	F	C
Schizophrenia	F	C
ADHD	F	C
Oppositional Defiant Disorder	F	C
Conduct Disorder	F	C
Tourette's	F	C
Autism	F	C
Asperger's	F	C
Alcoholism	F	C
Substance Abuse	F	C
Psychiatric Hospitalization	F	C

 Nurse Initials ____________ Date ______________ / Physician Initials ______________ Date _________

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If concerned about Autism, answer the following four questions:

1. Has anyone suggested your child might have a developmental delay: Yes No

2. Has anyone suggested your child might be mentally handicapped or retarded?
   Yes No

3. Will your child look at people, talk to them and interact with them the way you would expect?
   Yes No

4. Does your child do any of the following? Check all that apply.
   - ❑ Body rocking
   - ❑ Head banging
   - ❑ Hand flapping
   - ❑ Toe walking
   - ❑ Repetitive nonsense sounds

If your child has problems with social skills answer the following questions:

1. Does your child prefer to play alone or with others?
   Alone With others
2. Does your child have close friends?
   Yes No
3. What are your child's hobbies?
4. Does your child seem to feel remorse for doing wrong things?
   Yes No
5. Does your child ever feel guilty even when s/he hasn't done anything terribly wrong?
   Yes No
6. Does your child make negative statements about him/herself?
   Yes No
7. Does your child get along with his/her siblings?
   Yes No
8. Does your child get picked on or teased?
   Yes No

By whom: ___________________________

9. Does your child get along with Mom?
   Yes No
10. Does your child get along with Dad?
    Yes No
11. Is there anything else that I should know? _______________________