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CHILD/TEEN HISTORY

Place a check for each symptom that applies:

Q Suicidal thoughts
Q Depression/sadness
Q Recurrent/intrusive thoughts
Q Loss of appetite
Q Weight loss
Q Overeating
Q Weight gain
Q Difficulty sleeping
Q Apathy
Q Fatigue
Q Loss of interest in almost all activities
Q Feeling worthless
Q Feelings of hopelessness
Q Poor self esteem
Q Sexual problems
Q Anorexia or Bulimia
Q Unmotivated
Q Dependent
Q Quiet
Q Resists change
Q Wetting bed or clothes
Q Bowel movements in underwear
Q Emotional
Q Immature
Q Is very fidgety
Q Can't remain seated
Q Can't wait his/her turn when playing with others
Q Answers before s/he hears the whole question
Q Rarely follows other's instructions
Q Destroys other people's property
Q Is cruel to animals
Q Starts fights with others
Q Homicidal thoughts
Q Anxiety/nervousness
Q Nightmares
Q Recurrent/intrusive disturbing recollections or dreams
Q Overwhelming need to perform certain behaviors/rituals
Q Excessive fears or phobias
Q Significant concerns with physical problems
Q Poor frustration tolerance
Q Explosive anger
Q Rapid mood changes
Q Euphoria (feel on top of the world)
Q Racing thoughts
Q Decreased need for sleep
Q Aggressive
Q Visual or auditory hallucinations
Q Stomach aches
Q Bizarre behavior
Q Shy and withdrawn
Q Self-mutilates
Q Self-stimulates
Q Exhibits sexually inappropriate behavior
Q Risk-taking
Q Is cruel to other people
Q Swears a lot
Q Steals things without people knowing on several occasions
Q Often runs away from home and stays away overnight
Q Easily lies to others
Q Firesetting
Q Doesn't go to school
Q Breaks into other people's property
Q When fighting, has used a weapon
Q Other unusual behavior: _____

Indicate which stressors the child is experiencing currently (within last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
____	____	Death of family member	____	____	Illness of family member	____	____	Illness of friend
____	____	Personal injury/illness	____	____	Parents separated	____	____	Parents divorced
____	____	Conflicts with family	____	____	Conflicts with friends	____	____	Conflicts at school
____	____	Academic difficulties	____	____	Change in residence	____	____	Legal problems
____	____	Sexual assault	____	____	Incest/sexual abuse	____	____	Physical abuse
____	____	Verbal/emotional abuse	____	____	Other problems: _____ _____			

Is s/he currently receiving therapy?_____ From who?_____
When did s/he start therapy? _____ For what problems(s)? _____
_____

List current psychiatric medications and dosages: _____
Has s/he received therapy in the past?_____ From who? _____

When (Start and finish): _____ For what problem(s)? _____
_____
List past psychiatric medications:_____
Has s/he been hospitalized for psychological problems? _____ When? _____
Where was s/he hospitalized? _____
Has s/he ever attempted suicide?_____ When?_____ How?_____

Circle substances s/he currently uses (Even if only occasionally or in small amounts):
Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers
Amphetamines ("Speed") Crank Crack Cocaine Opiates (Heroine, Opium, Codeine, etc.)
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust") Other: _____
Circle substances s/he has taken in the past (Even if only occasionally or in small amounts):
Alcohol Tobacco Marijuana Barbiturates ("Downers") Tranquilizers
Amphetamines ("Speed") Crank Crack Cocaine Opiates (Heroine, Opium, Codeine, etc.)
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.) PCP ("angel dust") Other: _____

Has your child had a prior psychological or neuropsychological evaluation? Yes ___ No ___ If yes, complete this information:
Name of psychologist: _____
Address: _____
Phone: _____ Date of and reason for this evaluation: _____
Findings of the evaluation: _____

DOCTORS NOTES

Birth and Developmental History

Place of Birth: _____ Were parents married at time of birth?_____
Was mother under a doctors care during the pregnancy?_____ Was the child adopted?_____ If so, at what age?_____

Circle any illnesses during pregnancy:
Anemia Toxemia Herpes Measles German measles Bleeding
Kidney disease Heart disease Hypertension Abdominal trauma Infection Diabetes

Medications taken during pregnancy:_____
Were drugs or alcohol taken during pregnancy? Yes ___ No ___ If yes, specify:_____
Was there significant emotional stress during pregnancy? Yes ___ No ___ If yes, name stressors: _____
Was the birth: On time ___ Premature ___ (By how long _____) Late ___ (By how long _____)
Was labor: Spontaneous ___ Induced ___ Duration of labor___ (Hours) Cesarean required?_____
Was the presentation: Normal ___ Breach ___ Transverse (Crosswise) ___ Posterior first ___
Did the baby experience any of these problems: Fetal distress ___ Prolapsed cord ___ Low placenta (Placenta previa) ___ Premature separation of the placenta (Abruptio placenta) ___ Cord wrapped around neck ___
Any other problems that mother or child had: _____
Was general anesthesia used? _____Were forceps used? _____Were there breathing problems?_____
Birthweight:_____ Length:_____

Circle those that apply to the first few weeks after birth:
Excessive sleeping Laziness Irritability Excessive crying Stiffness Limpness
Tremors Twitching Feeding difficulties Vomiting Jaundice Other_____

Transfusions required?____ Medication required? (For what)_____
Surgery required? (For what)_____

Give approximate ages that developmental milestones were achieved:
Head control_____ Rolled over_____ Sat alone_____ Walked____ Run____
Said first word_____ Used sentences_____ Self feeding w/ utensils_____ Toilet trained____
Dress self_____ Tie shoes_____ Color within lines_____

Circle any problems that occurred in later development:
Hearing Speaking Stuttering Reading Writing Spelling Arithmetic Behavior Hyperactivity
Attentional difficulties Seizures Coordination
List family members with developmental or learning problems:_____

Medical History

Please check all the conditions that have been diagnosed.

___ AIDS, ARC or HIV+	___ Diabetes	___ Immune system disease	___ Poisoning
___ Allergies	___ Enzyme deficiency	___ Jaundice	___ Polio
___ Arthritis	___ Encephalitis	___ Kidney problems	___ Parkinson's Disease
___ Asthma	___ Ear Infections	___ Liver disorder	___ Rheumatic Fever
___ Abscessed ears	___ Fevers (104 or higher	___ Lung disease	___ Radiation exposure
___ Arteriosclerosis	___ Genetic disorder	___ Lead poisoning	___ Scarlet fever
___ Bleeding disorder	___ Head injury/concussion	___ Leukemia	___ Senility (Dementia)
___ Blood disorder	___ Heart problems	___ Metabolic disorder	___ Stroke or TIA
___ Broken bones	___ Hereditary disorder	___ Meningitis	___ Tuberculosis
___ Brain disease	___ Headaches	___ Measles	___ Tumor
___ Cerebral palsy	___ Hearing problems	___ Mumps	___ Thyroid disease
___ Colds (excessive)	___ Huntington's disease	___ Malnutrition	___Venereal disease
___ Chicken pox	___ Hypertension	___ Multiple sclerosis	___ Vision problems
___ Hormone problems	___ Oxygen deprivation	___ Carbon monoxide poisoning	___ Pneumonia
___ Cancer	___ Hazardous substance exposure		___ Whooping cough

___ Other medical/physical problems_____
Has your child ever been diagnosed with epilepsy or a seizure disorder Yes ___ No ___
If yes, check the one you have been diagnosed with.
PARTIAL GENERALIZED ___ UNCLASSIFIED TYPE

List any medications currently being taken (over-the-counter or prescription), and the dosage.
Medication and Dosage
1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____
List any medications your child is ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):
_____
_____
_____
_____
_____
Outpatient Surgeries (When, where and for what):
_____
_____
_____

Name of family physician:_____
Address:_____
Phone:_____ Date of your last medical check-up:_____

Family History

Father's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____
Mother's Name _____ Age _____ Health Problems _____
Education _____ Occupation _____ Employer _____

Date of parent's marriage _____ Years married ____ Current marital problems? ____
If separated, give date _____ If divorced, date_____ Previous marriages? (Father) _____ (Mother)_ _____
Subsequent marriages? (Father)_____ (Mother)_____

If divorced, current custody arrangement _____

Please provide information regarding step-parents if parents are divorced:

Name	Age	Education	Occupation	Date Married	# Years
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Names and ages of brothers and sisters (Include step-brothers and step-sisters):
_____
_____
_____

List anyone else who has lived in the home during your child's life: _____

List names of any family members (e.g. Immediate and distant relatives) with any of the following problems:
Alcohol/drug abuse _____
Criminal history _____
Emotional/behavioral problems _____
Medical problems (e.g. Heart disease, Cancer, Seizures) _____
Learning/developmental problems _____

DOCTORS NOTES

Social History

How long has s/he lived in current home? _____ Apartment or house? _____ How long in this town? _____
How many changes in residence in child's lifetime? _____ Ages moves occurred? _____
What towns has s/he lived in the past?_____ _____

How many friends does your child have in your neighborhood?___ First name of best friend in neighborhood: _____
How often does s/he play with neighborhood friends? _____ Any conflict problems (What type)? _____
What are his/her most frequent play activities? _____
How many friends does s/he have at school? _____ First name of best friend at school:_____

Is your child well liked/accepted at school? _____ Any conflict problems (What type)? _____
_____
Does s/he have a girlfriend/boyfriend? _____ First name: _____ Involved how long? _____
Is this relationship stable? _____ Type of problems (if any):_____
How many girlfriends/boyfriends in the past? ___ Starting at what age: ___ Is s/he currently sexually active?_____
When did s/he first become sexually active? ____ Currently using birth control (What type)? _____

Any aborted pregnancies/miscarriages? ____ Any children outside of marriage? ____ Names/Ages: _____

List clubs and organizations that s/he is involved in: _____
_____
Is your child involved in a church/temple? _____ Denomination: _____ Attend how often? _____

What time/activities do you share with your child?_____
Please describe you last vacation (when & where):_____

Educational History
Current grade (Or highest grade/degree completed): _____ Current school: _____
Past schools attended (List in order): _____
_____
Hardest subject(s): _____ Favorite subject(s): _____
Grades earned in elementary school: _____ Junior High G.P.A _____ High School G.P.A. _____

Grades repeated: _____ Learning problems (what subjects): _____
Special education placement (Type): _____ During which grades: _____
IEP_____ 504_____

Extracurricular activities (Music, Sports, Clubs, etc.) _____
Expulsions/suspensions/conduct problems (Type of problem and date): _____
Additional schooling or non-academic training: _____

DOCTORS NOTES

Occupational History
Present employer: _____ Position: _____
Length of employment: _____ Hours worked per week _____ Current responsibilities: _____

List previous employment (Include dates and type of work):
_____
_____
_____
_____
_____
Have you ever been terminated from a job (Please explain): _____

At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)?
Yes ___ No ___ If yes, explain: _____
Have you ever been injured on the job? Yes ___ No ___ If yes, explain: _____

Legal History
Present legal problems (Describe): _____
Past arrests (For what?): _____
Convictions (For what?): _____
Time served in juvenile hall, jail or prison (Give dates and locations): _____
_____