**Child Mental Health History Form**

Please complete this form and either fax to 888-262-4895 or email (copy/paste or as an attachment) to info@nellpeiken.com. n cases where the child’s parents hold joint legal custody, both parents must give consent for evaluation and treatment.

**Please note: I require that clients be currently engaged in psychotherapy.**

If you have any questions about this form please email me at the address above or call/text me at 978-406-9043.

Nell Peiken, Psychiatric Mental Health Nurse Practitioner

Child’s Name:

Child’s Date of Birth:

Phone number:

E-mail address:

Child’s Health Insurance:

What issue(s) have led you to seek a medication evaluation for your child? What is your child’s psychiatric diagnosis (if known)?

How long has your child been seeing their current therapist?

How frequent are the visits?

Has your child ever been treated by a psychiatrist or psychiatric nurse prescriber?

If so, what led them to end treatment with this provider?

Is your child currently taking any psychiatric medication(s)?

If so, please list the medication(s) your child is currently taking as well as when each medication was first prescribed.

Has your child taken a psychiatric medication in the past that he or she is no longer taking?

If so, what was it, when was it first prescribed and what led your child to stop taking this medication?

Does your child have a history of self-harming or suicidal behaviors?

If so, please describe.

Has your child ever been to an emergency room for a psychiatric evaluation?

If so, what was the outcome of this/these evaluation(s)?

Has your child ever been in a psychiatric hospital?

If so, what were the (approximate dates) of the hospitalization(s)?

What led up to this/these hospitalization(s)?

Has your child ever had a problem with drug or alcohol use?

If so, what treatment, if any, has he or she had?

Has your child ever engaged in disordered eating (binging/purging/restricting)?

If so, what treatment, if any, has he or she had? Please note that I require all clients with eating disorders to be in treatment with a registered dietician and a primary care provider as well as a therapist.

Has your child ever been assaultive toward others?

If so how?

Are there any other safety concerns?

Is your child currently being treated for a non-psychiatric medical condition?

What medications, if any, is your child currently taking?

Has your child ever seen a medical specialist?

If so, what diagnosis was given and what treatment was required?

Has your child ever been diagnosed with a developmental or learning disability?

If so, what is the nature of the disability and what kind of accommodations has he or she required?

Thank you very much for completing this form. Once I receive it I will contact you shortly.