**CHILD PATIENT HISTORY**

*Demographics*

Name: Date of Birth: Age:

 Child Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Child Medical History*

*Pregnancy and Birth History*

Child’s gestational age at birth (number of weeks of pregnancy): \_\_\_\_\_\_\_\_\_

APGAR scores \_\_\_\_\_\_\_\_\_

Prenatal care: Y or N (circle one) Was the pregnancy wanted?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnancy complications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery method: Vaginal C-Section VBAC Forceps Suction

Was delivery induced? Y or N (circle one) If so, why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Delivery complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Developmental Milestones*

At what age did the child sit \_\_\_\_\_\_\_\_\_\_ crawl \_\_\_\_\_\_\_\_\_ walk \_\_\_\_\_\_\_\_\_\_ talk \_\_\_\_\_

Did the child experience developmental delays? Y or N (circle one) If so, which delays?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child undergone developmental therapy (speech or motor)? Y or N (circle one) Type of therapy and ages of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child experience sensory issues? Y or N (circle one)

Does the child use corrective devices?

vision (glasses) hearing aid walking assistance other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please circle the following medical problems the child has experienced:*

Allergies Arthritis Asthma Broken Bones (specify) Cancer Diabetes

Eating Disorder Emotional problems Epilepsy/Seizures Fainting MS CP

Head injury/concussion HIV+/AIDS Loss of Consciousness Headaches/Migraines Hearing Problems Heart Problems Hepatitis Stroke High / Low blood pressure Liver problems Lung problem Organ transplant STD Osteoporosis Surgery

Shortness of breath Substance/Alcohol abuse Tobacco use Thyroid problem

Other/ Details: \_\_\_\_\_\_

*Child Mental and Emotional History*

*Please the following psychological problems that pertain to the child:*

Alcohol use Anger Anxiety/nervousness Appetite Body image issues Temper Depression Difficulty making decisions Educational problems

Feelings of inferiority Financial problems Health problems Illicit Drug Use Insomnia Lack of energy Loneliness Fatigue Legal matter Marital problems Memory problems Nightmares Parenting Occupational problems

Sleep issues Post-traumatic stress Prescription drug abuse Divorce Stress

Self-Control Separation Sexual problems Social problem Stomach trouble

Suicidal thoughts Suicide attempt Homicidal Thoughts Cutting/ Self-harm Tobacco Abuse Pornography Hear or see things others do not hear or see Panic Forgetfulness Social difficulties/ Peer issues Oppositional Lying/ Stealing Concussion / Head Injury

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever been abused? Y or N (circle one)

Sexually Verbally Physically Mentally Emotionally Other: \_\_\_\_\_\_\_\_\_\_\_\_ (circle all that apply)

If yes, who was the abuser? \_\_\_

If yes, provide relevant details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child ever been admitted to an in-patient psychiatric hospital? Y or N

Has the child ever participated in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the previous treatment beneficial? Y or N (circle one)

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychological testing?\_\_\_\_\_ Age at time of testing?

Diagnosis Assigned? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications the child is *currently* prescribed and/or are using, and why:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication  | Dose | How many times per day? | Why is the medication prescribed? |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

Please list all medications the child has *previously* been prescribed or has used *in the past*, and why:

|  |  |  |
| --- | --- | --- |
| Medication  | Why was the medication prescribed? | Why was the medication stopped (include allergic reactions)? |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

*Family of Origin*

Parents’ Current Marital Status:

*S*ingle Married Widowed Separated Divorced Common Law

Child’s father: Age (current, if living): \_\_\_\_\_\_

Occupation: Highest Level of Education:

Describe the father/child relationship:

Child’s mother: Age (current, if living):\_\_\_\_\_\_\_\_\_\_

Occupation: Highest Level of Education: \_\_\_\_\_

Describe the mother/child relationship:

Other Important Family Members Age Relationship to Patient

 \_\_\_\_\_\_

 \_\_\_\_\_\_

 \_\_\_\_\_\_

 With whom does the child reside?

Family Members/Others Residing in Home Age Relationship to Patient

 \_\_\_\_\_\_

Have there been any significant deaths or losses in your family? Y or N (circle one) If yes, please explain:

Describe court ordered visitation/ custody/ guardianship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian ad litem, name and contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe childhood and/ or adolescence:

Family Psychiatric History

*Indicate which family member:*

 *Maternal Family Psychiatric History Paternal Family Psychiatric History*

Depression/Sadness Depression/Sadness \_\_\_\_\_\_

Suicidal Ideation/Attempt Suicidal Ideation/Attempt \_\_\_\_\_\_

Anxiety/Excessive Worry Anxiety/Excessive Worry

Panic Attacks Panic Attacks \_\_\_\_\_\_

Bipolar Disorder Bipolar Disorder

Obsessive-Compulsive Tendencies Obsessive-Compulsive Tendencies \_\_\_\_\_\_

Schizophrenia Schizophrenia

Attention Problems/ADHD Attention Problems/ADHD

Learning Problems Learning Problems

Alcohol/Drug Use Alcohol/Drug Use

Problems with the Law Problems with the Law

Seizures Seizures

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Child Educational History*

Grade level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of school:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current grades:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learning difficulties (subject and describe history):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child repeated a grade? If so, which grade and why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past learning and education history:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Behavioral issues at school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Child Legal History*

Has the child been arrested or experienced any legal issues? Y or N (circle one) If yes, please explain: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Child / Family Recreational and Leisure Activities*

Does the child have any hobbies? Y or N (circle one) Details:

Does the child engage in pleasurable activities with others? Y or N (circle one)

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child enjoy spending time with and interact with peers? Y or N

Does the child complain of being bullied or rejected from peers? Y or N

Does the child attend religious services? Y or N (circle one) Are spiritual issues important to the child? Y or N (circle one) Details:

*\*Your child is unique and our treatment and testing will be specifically designed for your child’s needs. Are there other current factors important for us to know about your child?:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_