# Child History Form

Date _____

Name _____ DOB _____ Age _____

Referred by? _____

Child's Current Problems: Please list/describe starting with the most serious.

Treatment: What kinds of things have you tried in order to take care of the problems? Have you seen other professionals? *(please see medication review form)*

Other Treating Clinicians:

Past Psychiatric Problems: Has your child been evaluated/treated for other psychiatric problems? Medications? Please explain:

School: Please describe your child's functioning at school. Are there any problems? What are his/her likes/dislikes?

Peer Relations: Please describe how your child gets along with other children.

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# Child History Form
## MEDICAL INFORMATION

### A. Present Medical Health:

1. Medications:
   a. Current medication No/_____
   _____
   _____
   b. Any other medications? Herbs? Vitamins? No/_____
   c. Medication allergies No/_____

2. How is your child's general health? Excellent Good Fair Poor

3. Current Pediatrician _____
   Date of last exam _____

4. Did the child in the past or does he/she currently have a problem with:

| | | | |
|---|---|---|---|
| Head? | YES | NO | PAST |
| Eyes? | YES | NO | PAST |
| Ears? | YES | NO | PAST |
| Nose? | YES | NO | PAST |
| Throat? | YES | NO | PAST |
| Respiratory System? | YES | NO | PAST |
| Heart and Blood Vessels? | YES | NO | PAST |
| Digestive Tract? | YES | NO | PAST |
| Genito-Urinary System? | YES | NO | PAST |
| Muscles? | YES | NO | PAST |
| Bones? | YES | NO | PAST |
| Hormone-System? | YES | NO | PAST |
| Brain and Nerves? | YES | NO | PAST |

5. Girls only:
   Age of onset of menses? _____
   Is menstruation irregular? _____ YES NO NA

### B. Past Medical History

1. Has your child ever been hospitalized? (When? Why?) YES NO
   _____
2. Have/had any serious illness? Injuries? YES NO
   _____
   _____
3. Have/had any operations? YES NO
   _____
4. Have/had any allergies/asthma? _____ YES NO
5. Immunizations: Are they up to date? YES NO NOT SURE *
6. Hearing:
   a. Has your child had any hearing problems? YES NO NOT SURE
   b. Has anyone else questioned the child's hearing ability? YES NO NOT SURE
   c. Has your child ever complained of hearing problems? YES NO NOT SURE
   d. Have there been any chronic ear infections? YES NO NOT SURE
   e. Have there been any illnesses involving the ears? YES NO NOT SURE
7. Vision:
   a. Has your child had any eye problems? YES NO NOT SURE
   b. Has your child worn glasses? YES NO NOT SURE
   c. Has there been any problem with "lazy eye"? YES NO NOT SURE
   d. Has there been any type of eye therapy for any reason? YES NO NOT SURE

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8. Head or Nerve Problems: Has your child had any of the following?

| | | | |
|---|---|---|---|
| a. Severe headaches? | YES | NO | NOT SURE |
| b. Seizures? | YES | NO | NOT SURE |
| With high fever? | YES | NO | NOT SURE |
| Medications for seizures? | YES | NO | NOT SURE |
| c. Loss of consciousness (blackout)? | YES | NO | NOT SURE |
| d. Hit in the head? | YES | NO | NOT SURE |
| e. Dizziness? | YES | NO | NOT SURE |
| f. Double vision? | YES | NO | NOT SURE |
| g. Lack of coordination? | YES | NO | NOT SURE |
| h. Memory problems? | YES | NO | NOT SURE |
| i. History of encephalitis/Meningitis? | YES | NO | NOT SURE |
| j. Momentary lapses of consciousness? | YES | NO | NOT SURE |
| l. Trance-like episodes? | YES | NO | NOT SURE |
| m.Tremor? | YES | NO | NOT SURE |
| n. Trouble walking? | YES | NO | NOT SURE |

9.Sleep issues:

| | | | |
|---|---|---|---|
| a. Problems falling asleep? | YES | NO | NOT SURE |
| b. Problems staying asleep? | YES | NO | NOT SURE |
| c. Problems waking early in the morning? | YES | NO | NOT SURE |
| d. Nightmares? | YES | NO | NOT SURE |
| e. Night terrors? | YES | NO | NOT SURE |
| f. Snoring? | YES | NO | NOT SURE |
| g. Sleep walking? | YES | NO | NOT SURE |
| h. Sleep talking? | YES | NO | NOT SURE |

10. Appetite:

| | | | |
|---|---|---|---|
| a. Has your child ever lost a lot of weight? | YES | NO | NOT SURE |
| b. Has your child ever seemed afraid of eating? | YES | NO | NOT SURE |
| c. Would you describe your child as having a 'poor" appetite? | YES | NO | NOT SURE |
| d. Has your child ever gained a lot of weight? | YES | NO | NOT SURE |
| e. Has your child ever had an excessive interest in eating? | YES | NO | NOT SURE |

11. Heart problems: Has your child had any of the following?

| | | | |
|---|---|---|---|
| a. Hypertension/high blood pressure? | YES | NO | NOT SURE |
| b. Cardiac Conduction Issues | YES | NO | NOT SURE |
| c. Congenital Cardiac Issues (i.e. murmer, etc) | YES | NO | NOT SURE |
| d. Structural Cardiac Issues | YES | NO | NOT SURE |
| e. Shortness of breath on exertion? | YES | NO | NOT SURE |
| f. Syncope/fainting spells | YES | NO | NOT SURE |
| g. EKG/electrocardiogram. | YES | NO | NOT SURE |
| h. Echocardiogram | YES | NO | NOT SURE |

12. Other:

| | | | |
|---|---|---|---|
| a. Has your child had many doctor or emergency room visits? | YES | NO | NOT SURE |
| b. Has there ever been excessive fluid intake? | YES | NO | NOT SURE |
| c. Has there ever been excessive urination? | YES | NO | NOT SURE |
| d. Have there been urinary tract infections? | YES | NO | NOT SURE |
| e. Does this child <u>often</u> mention bodily complaints? | YES | NO | NOT SURE |

13. Has your child:

| | | | |
|---|---|---|---|
| a. Tried alcohol? | YES | NO | NOT SURE |
| b. Gotten into trouble at home, school or community because of alcohol? | YES | NO | NOT SURE |
| c. Tried other drugs? Which ones? _____ | YES | NO | NOT SURE |
| d. Gotten into trouble at home, school or community because of drugs? | YES | NO | NOT SURE |
| e. Used tobacco regularly? | YES | NO | NOT SURE |

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# Child History Form

## FAMILY

| A. Family Information: | Age | Degree Grade | Address/Phone if different |
|---|---|---|---|
| Father:_____<br>Biological ( ) Step ( ) Foster ( )<br>Occupation: | | | _____<br>_____ |
| Mother:_____<br>Biological ( ) Step ( ) Foster ( )<br>Occupation: | | | _____<br>_____ |
| Children (In Chronological Order):<br>_____<br>_____<br>_____ | | | _____<br>_____<br>_____ |
| Others in Home | | | |

Current Date of: Marriage_____ Separation_____ Divorced_____

Prior: Mother married to:_____ Date Married:_____ Date Terminated:_____

Father married to:_____ Date Married:_____ Date Terminated:_____

_____

_____

_____

## B. Home Life:

0= No Problem 5= Severe

Problem

| | |
|---|---|
| 1. Is there a problem with quarreling with mother? | 0 1 2 3 4 5 |
| 2. Does your child confide problems with his/her mother? | YES NO NOT SURE |
| 3. Does your child have talks or discussions with his/her mother? | YES NO NOT SURE |
| 4. Overall, how would you rank your child's relationship to his/her mother? | 0 1 2 3 4 5 |
| 5. Is there a problem with quarreling with father? | 0 1 2 3 4 5 |
| 6. Does your child confide problems with his/her father? | YES NO NOT SURE |
| 7. Does your child have talks or discussions with his/her father? | YES NO NOT SURE |
| 8. Overall, how would you rank your child's relationship to his/her father? | 0 1 2 3 4 5 |
| 9. Is there a problem with quarreling with brothers and sisters? | 0 1 2 3 4 5 |
| 10. Overall, how would you rank your child's relationship with siblings? | 0 1 2 3 4 5 |

Explanation of above:

_____

_____

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# Child History Form

## C. Family Background:

Has anyone in the patient's family had:

| | | | | |
|---|---|---|---|---|
| "Nervous breakdown"? | YES | NO | NOT SURE | WHO?_____ |
| Psychiatric hospitalization? | YES | NO | NOT SURE | WHO?_____ |
| Depression? | YES | NO | NOT SURE | WHO?_____ |
| Manic-depressive | YES | NO | NOT SURE | WHO?_____ |
| Bipolar disorder? | YES | NO | NOT SURE | WHO?_____ |
| Suicide? | YES | NO | NOT SURE | WHO?_____ |
| Alcoholism? | YES | NO | NOT SURE | WHO?_____ |
| Drug abuse? | YES | NO | NOT SURE | WHO?_____ |
| Schizophrenia? | YES | NO | NOT SURE | WHO?_____ |
| Obsessive-compulsive disorder? | YES | NO | NOT SURE | WHO?_____ |
| Panic attacks? | YES | NO | NOT SURE | WHO?_____ |
| Anxiety Disorder | YES | NO | NOT SURE | WHO?_____ |
| Tourette's disease/tics? | YES | NO | NOT SURE | WHO?_____ |
| Anorexia or bulimia? | YES | NO | NOT SURE | WHO?_____ |
| ADD/ADHD | | | | |
| School problems? | YES | NO | NOT SURE | WHO?_____ |
| Learning disabilities? | YES | NO | NOT SURE | WHO?_____ |
| Mental retardation? | YES | NO | NOT SURE | WHO?_____ |
| Autism? | YES | NO | NOT SURE | WHO?_____ |
| Asperger's Syndrome? | YES | NO | NOT SURE | WHO?_____ |
| Epilepsy? | YES | NO | NOT SURE | WHO?_____ |
| Alzheimer's disease? | YES | NO | NOT SURE | WHO?_____ |
| Wilson's disease? | YES | NO | NOT SURE | WHO?_____ |
| Parkinson's disease? | YES | NO | NOT SURE | WHO?_____ |
| Heart attack before the age of 50 | YES | NO | NOT SURE | WHO?_____ |
| Unexplained sudden death. | YES | NO | NOT SURE | WHO?_____ |
| Arrhythmia. | YES | NO | NOT SURE | WHO?_____ |
| Congenital cardiac issues | YES | NO | NOT SURE | WHO?_____ |
| Structural Cardiac issues | YES | NO | NOT SURE | WHO?_____ |
| Syncope/fainting | YES | NO | NOT SURE | WHO?_____ |

### Other Comments

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