**PSYCHOLOGY HEALTH GROUP**

A Group of Independent Practitioners

CHILD/ADOLESCENT PATIENT HISTORY

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and relationship of person completing this form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you known this child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I. IDENTIFYING INFORMATION:**

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Education: Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 List any special education services or grade retentions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Living Arrangements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Adopted: \_\_\_\_\_ Yes \_\_\_\_\_\_\_ No If yes at what age? \_\_\_\_\_\_\_\_\_\_\_\_\_

 Parental status: \_\_\_\_\_\_\_\_ Together \_\_\_\_\_\_\_ Separated \_\_\_\_\_\_\_ Divorced

 Custodial Parent(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If one of the biological parents does not live with the child, where does that parent live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List siblings and others who are living with the patient, their ages, and how they are related to the patient. If siblings are not in the house please indicate. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. PRESENTING PROBLEM**

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

 Specific concerns (problems/symptoms) that prompted the child to be brought to Psychology Health Group?

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

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 When did the problems first become evident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Specific stressors present in the child’s or parent’s lives over the past couple of months or years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**III. SYMPTOM CHECKLIST (**If the child has experienced any of the following in the last three months, please check)

 What time does the child normally go to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What time does the child normally wake up ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Occasionally/

 Yes Sometimes No

Sleeping too much or too little ………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Difficulty getting to sleep ………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

Waking up in the middle of the night and having difficulty falling back asleep.................................... \_\_\_\_ \_\_\_\_ \_\_\_\_

 How often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What wakes the child up \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.......... \_\_\_\_ \_\_\_\_ \_\_\_\_

Wakes too early………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Nightmares……………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Bedwetting……………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Feeling depressed most of the day…………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Diminished pleasure……………………………………………………………………………………, \_\_\_\_ \_\_\_\_ \_\_\_\_

Loss of motivation……………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Loss or gain of weight or appetite change…………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Loss of energy…………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Feelings of worthlessness or excessive or inappropriate guilt……………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Diminished ability to think or concentrate ……………………………………………………………,, \_\_\_\_ \_\_\_\_ \_\_\_\_

Indecisiveness…………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Recurrent thoughts of death or suicide……………………………………………………………….… \_\_\_\_ \_\_\_\_ \_\_\_\_

Suicidal plans…………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Previous suicidal actions ……………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Feelings of hopelessness ……………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Moodiness ………………………………………………………………………………………..…… \_\_\_\_ \_\_\_\_ \_\_\_\_

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Occasionally/

 Yes Sometimes No

Forgetfulness ……………………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

Crying spells …………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Feeling irritable or restless …………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Thoughts going too fast …………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

Dislike of his/her body …………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

Lack of confidence ……………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

**Circle the number that best describes your child’s home behavior over the past six months:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Never** **Rarely** | **Sometimes** | **Often** | **Very** **Often**  |
| Fails to give close attention to details or makes careless mistakes in schoolwork  | **0** | **1** | **2** | **3** |
| Fidgets with hands or feet or squirms in seat  | **0** | **1** | **2** | **3** |
| Has difficulty sustaining attention in tasks or play activities | **0** | **1** | **2** | **3** |
| Leaves seat in classroom or in other situations in which remaining seated is expected.  | **0** | **1** | **2** | **3** |
| Does not seem to listen when spoken to directly  | **0** | **1** | **2** | **3** |
| Runs about or climbs excessively in situations in which it is inappropriate | **0** | **1** | **2** | **3** |
| Does not follow through on instructions and fails to finish work | **0** | **1** | **2** | **3** |
| Has difficulty playing or engaging in leisure quietly  | **0** | **1** | **2** | **3** |
| Has difficulty organizing tasks and activities  | **0** | **1** | **2** | **3** |
| Is “on the go” or acts as if “driven by a motor”  | **0** | **1** | **2** | **3** |
| Avoids tasks (e.g. schoolwork, homework) that require sustained mental effort | **0** | **1** | **2** | **3** |
| Talks excessively | **0** | **1** | **2** | **3** |
| Loses things necessary for tasks or activities | **0** | **1** | **2** | **3** |
| Blurts out answers before questions have been completed  | **0** | **1** | **2** | **3** |
| Is easily distracted  | **0** | **1** | **2** | **3** |
| Has difficulty awaiting his/her turn  | **0** | **1** | **2** | **3** |
| Is forgetful in daily activities  | **0** | **1** | **2** | **3** |
| Interrupts or intrudes on others  | **0** | **1** | **2** | **3** |

**If the child has experienced any of the following in the last *three* months, please check**:

 Occasionally/

 Yes Sometimes No

 Motor or vocal tics……………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Behavior problems in school or at home……………………………………… ………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Bullies and intimidates others………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Has used a weapon to hurt others........................................................................................... \_\_\_\_ \_\_\_\_ \_\_\_\_

 Physically cruel to people…………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Physically cruel to animals…………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Has stolen while confronting a victim……………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Has forced someone into sexually activity.............................................................................. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Fire setting with the intention of harm..................................................................................... \_\_\_\_ \_\_\_\_ \_\_\_\_

 Deliberate destruction of property........................................................................................... \_\_\_\_ \_\_\_\_ \_\_\_\_

 Has broken into someone else’s house, car, etc…………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Often lies to obtain goods or favors or to avoid obligation……………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Shoplifting……………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Stays out late despite parental prohibition................................................................................ \_\_\_\_ \_\_\_\_ \_\_\_\_

 Has run away from home overnight at least twice………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Truant from school.................................................................................................................... \_\_\_\_ \_\_\_\_ \_\_\_\_

 **Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Occasionally/

 Yes Sometimes No

 Has the child deliberately inflicted pain on him/herself ?........................................................... \_\_\_\_ \_\_\_\_ \_\_\_\_

 Has the child deliberately inflicted pain on animals or others ?................................................. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Has the child been preoccupied with fire or weapons? ............................................................. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Often loses temper…………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Argues with adults……………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Defies adult rules or requests………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Deliberately annoys people........................................................................................................ \_\_\_\_ \_\_\_\_ \_\_\_\_

 Blames others for child’s mistakes or misbehavior………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Easily annoyed by others…………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Angry and resentful…………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Spiteful or vindictive……………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Has the child ever been arrested? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_

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

 Shortness of breath………………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Smothering sensation…………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Accelerated heart rate………………............................................................................................. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Trembling or shaking……………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Sweating or choking…………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Nausea or abdominal distress………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Feeling like he/she or the world is not real……………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Numbness or tingling…………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Hot flashes or chills…………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Chest discomfort………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Out of body experiences………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Fear of dying……………………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Fear of going crazy……………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 **Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Occasionally/

 Yes Sometimes No

 Fear of being in places where escape might be difficult or getting help would be difficult……. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Avoidance of one or more situations…………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Excessive worrying…………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Difficulty controlling worry…………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Restless or feeling keyed up or on edge………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Muscular tension daily…………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Fear of one or more situations ……………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Recurrent excessive distress when separated from home or a parent ……………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Persistent and excessive worry about losing or possible harm to parents …………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Worry about getting lost or kidnapped …………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Fearful or reluctant to go to school……………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Fearful or reluctant to be home alone…………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Persistent reluctance or refusal to go to sleep without being near a parent……………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Refusal to sleep away from home ………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Repeated nightmares ……………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Repeated physical complaints when separated from a parent ……………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Reluctant to speak in social situations …………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 An inability to ignore pain ………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Uncontrolled pain …………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Staring off into space, thinking of nothing, and losing awareness of the passage of time …. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Severe and frequent headaches ………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Unusual sexual curiosity or sexual activity ………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Does this child have a history of sexual, emotional, or physical abuse ………………………. \_\_\_\_ \_\_\_\_

 Has this child experienced a psychologically distressing event that is outside the range of

 usual human experience for this age? \_\_\_\_ \_\_\_\_

 Does the child have recurrent, intrusive recollections ………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Does the child have recurrent dreams or nightmares …………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Does the child act or feel as if the event were re-occurring ………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Have you taken this child to a number of physicians for a physical problem that they have

 had difficulty diagnosing or treating \_\_\_\_ \_\_\_\_

 If yes, please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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 Has this child had more than his/her share of illnesses or injuries……………………………. \_\_\_\_ \_\_\_\_

 **Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Occasionally/

 Yes Sometimes No

 Does your child do any odd or repetitive things ………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Counting objects …………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Checking locks, alarms, stove, etc. ……………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Worries about germs or dirt ……………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Obsessive cleaning ……………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Excessive hand washing or bathing …………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Plucking hair ……………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Making lists ………………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Needing things to be perfect …………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Unusual concern about appearance that interferes with school or socialization ………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Inflexible adherence to routines or rituals ………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Failure to develop peer relationships ……………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Lack of spontaneous seeking to share enjoyment, interests, achievements with others……. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Lack of varied, spontaneous make believe play or social imitative play (for age) …………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Worrisome eating behaviors ………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Making oneself throw up …………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Going without food for extended periods ………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Diet pills ………………………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Laxatives ……………………………………………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Binge eating ………………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

Eating non-nutritious substances (e.g. “Twinkies”) excessively ………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Re-chewing food …………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Persistent failure to eat adequately ………………………………………………………………... \_\_\_\_ \_\_\_\_ \_\_\_\_

 Significant failure to gain weight ……………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Significant loss of weight ……………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Hearing voices outside of his/her head…………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Hearing voices inside of his/her head ……………………………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Hearing a voice calling the child’s name or yelling at the child …………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 A voice telling the child that they are bad or telling them to hurt themselves………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Seeing things in the room other people don’t see ……………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Having distorted images ……………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Thinking that the TV or radio is talking directly to the child………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Believing that the child has special powers or is cursed ………………………………………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 Loss of previously acquired skills (language, social skills, bowel or bladder control) ………… \_\_\_\_ \_\_\_\_ \_\_\_\_

 **Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Occasionally/

 Yes Sometimes No

 Sensory experiences that he/she cannot explain:

 Visual ………………………………………………………………………………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Hearing …………………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Smell ……………………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Taste ……………………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

 Body sensations ………………………………………………………………………………….. \_\_\_\_ \_\_\_\_ \_\_\_\_

**IV. Past Mental Health History:**

Has your child ever been hospitalized for psychiatric problems ………………………………… \_\_\_\_ \_\_\_\_

 If so, how many times and at what age ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Has your child ever been hospitalized for substance abuse problems? ………………………… \_\_\_\_ \_\_\_\_

 If so, how many times and at what age ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Has your child taken any medications to treat psychiatric disorders ? …………………………. \_\_\_\_ \_\_\_\_ \_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Name of medication** | **Prescribing doctor** | **Approximate Date** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Has your child had any previous counseling or psychotherapy ?

|  |  |  |  |
| --- | --- | --- | --- |
| **Problem** | **Therapist** | **Approximate Date** | **Result of Treatment** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**V. Past Medical History:**

 **Developmental History:**

To the best of your knowledge, did any of the following prenatal, labor and delivery, or childhood problems occur during your child’s lifetime? Yes No

Illness of the mother during pregnancy …………………………………………………………....... \_\_\_\_\_ \_\_\_\_\_

Medications or drugs taken by mother during pregnancy…………………………………………. \_\_\_\_\_ \_\_\_\_\_

Mother’s age at birth of child was over 35 ………………………………………………………....... \_\_\_\_\_ \_\_\_\_\_

Abnormal length of or difficulty with labor (longer than 8-10 hours)……………………………….. \_\_\_\_\_ \_\_\_\_\_

Forceps delivery …………………………………………………………………………………………\_\_\_\_\_ \_\_\_\_\_

Cesarean section delivery ……………………………………………………………………………... \_\_\_\_\_ \_\_\_\_\_

Possible anoxia (lack of oxygen) in child during delivery……………………………………………. \_\_\_\_\_ \_\_\_\_\_

High fevers during childhood ………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

Childhood convulsions …………………………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Yes No

Childhood fainting spells ……………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

Childhood illnesses ……………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

Delay in toilet training …………………………………………………………………………………….\_\_\_\_\_ \_\_\_\_\_

Current lack of bladder control …………………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

Current lack of bowel control . …………………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

 Did this child have developmental delays? If so, age accomplished:

Sitting – age \_\_\_\_\_...................................................................................................................................... \_\_\_\_\_ \_\_\_\_\_

Crawling – age \_\_\_\_\_ ………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

 Walking – age \_\_\_\_\_ ……………………………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

 Talking in single words – age \_\_\_\_\_........................................................................................................ \_\_\_\_\_ \_\_\_\_\_

 Talking in word combinations – age \_\_\_\_\_ ……………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

 Clumsiness ……………………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

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

 Does this child have communication difficulties?

 Speech production ……………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

 Sound production ………………………………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

 Stuttering ………………………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

 Other: Please Explain : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Does this child have learning difficulties ?

 Reading ………………………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

 Writing skills …………………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

 Mathematics …………………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

 Other …………………………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

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

**B. General Health**

Any significant injuries …………………………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

 Head injuries ……………………………………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

 Visual problems ………………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

 Hearing problems ……………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

 Blackouts ……………………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

 Memory problems ……………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

 Onset of memory problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Language disturbances ………………………………………………………………………………... \_\_\_\_\_ \_\_\_\_\_

 Disturbance in coordination or gait ……………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

Episodes of uncontrolled behavior in the absence of provocation ……………………………………… \_\_\_\_\_ \_\_\_\_\_

 High blood pressure ………………………………………………………………………………………\_\_\_\_\_ \_\_\_\_\_

 Heart disease ……………………………………………………………………………………………. \_\_\_\_\_ \_\_\_\_\_

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Yes No

 Lung disease …………………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

 Asthma or allergies ……………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

 Cancer …………………………………………………………………………………………………… \_\_\_\_\_ \_\_\_\_\_

 Blood sugar too high or too low …………………………………………………………………………..\_\_\_\_\_ \_\_\_\_\_

 Glaucoma ……………………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

 Seizures ………………………………………………………………………………………………….. \_\_\_\_\_ \_\_\_\_\_

 Kidney disease ………………………………………………………………………………………….. ..\_\_\_\_\_ \_\_\_\_\_

 Liver disease ……………………………………………………………………………………………... \_\_\_\_\_ \_\_\_\_\_

 Thyroid disease …………………………………………………………………………………………. . \_\_\_\_\_ \_\_\_\_\_

 Have menstrual cycles started? (girls)………………………………………………………………… ….\_\_\_\_\_ \_\_\_\_\_

 If yes, at what age ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Is daughter more irritable, anxious, or depressed the week prior to her period? \_\_\_\_\_ \_\_\_\_\_

**C. Current prescription medications and dosage for all health problems** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**D. Prescription medications recently discontinued** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**E. Allergies and/or drug reactions** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**F. Hospitalizations (** date and reason) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**G. Present health problems** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**VI. Substance abuse by CHILD (** Please check appropriate boxes)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes**  | **No**  | **Past**  | **Present**  | **Frequency**  |
| Alcohol  | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| Caffeine  | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
| Cigarettes  | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 List type and frequency of over the counter drugs currently used \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 List any other drug use in the last year (including street drugs, e.g. marijuana, cocaine, speed )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**VII.** **Family of Origin History**

 **( A ) Mother** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mother’s previous marriages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Father** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Education \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Father’s previous marriages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Divorced \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

 ( **B )** Please list any significant Medical illnesses among blood relatives and the relationship to the patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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 **( C )** Is there any history of psychological problems in the child’s family of origin? \_\_\_\_\_\_ **Yes** \_\_\_\_\_\_ **No**

 (anxiety, depression, mood swings, erratic behavior, schizophrenia, ADHA, etc) If yes please list name and relationship to

 child, along with their problem. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Has anyone in the child’s family of origin received mental health treatment or had a hospitalization for emotional problems?

 If yes, please list their name and relation to the child along with their problem \_\_\_\_\_\_ **Yes** \_\_\_\_\_**No**

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

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 **( D )** Is there any history of alcohol or substance abuse in the child’s family of origin?(parents or siblings) \_\_\_\_\_\_ **Yes** \_\_\_\_\_**No**

If yes, please list their name and relation to the child along with their problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Has anyone in the child’s family of origin received treatment for alcohol or substance abuse? \_\_\_\_\_\_ **Yes** \_\_\_\_\_**No**

If yes, please list their name and relation to the child along with their problem \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **VIII.** Is this child presently involved with the Department of Human Services, Department of Children and Family Services, or the subject of a lawsuit?\_\_\_\_\_\_**Yes** \_\_\_\_\_\_ **No**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IX. Please describe how you discipline your child.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**X. Please describe any other helpful information about your child** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**XI. Please list family members who you believe are supportive of you and your child or who you can call upon to help you**

 **when you have difficulties with your child:**

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

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**XII. Please list friends or social groups who you believe would be supportive of you or who you can trust to help you when**

 **you have difficulties with your child:**

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

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Thank you for your time and patience in completing this questionnaire. Please present this history form to the receptionist for the clinician to review prior to your appointment.

All the answers and information contained in this history form are accurate to my knowledge. Any question or request for information left blank was done intentionally. I may not know the answer or I wish not to reveal this information at this time.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_