CHILD HISTORY FORM

(Full Name) First: _____ Last: _____ Middle: _____

DOB: _____ ☐ Male ☐ Female ☐ Transgender

Person Completing Form: _____ Relationship: _____

Has your child ever received mental health treatment? ☐ YES ☐ NO

If yes, where has your child received treatment before? What dates?

_____

_____

	Mother	Father	Grandmother	Grandfather	Sibling(s)	Aunts/Uncles
Depression	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐
Obsessive Compulsive Disorder	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐
Suicide Attempt	☐	☐	☐	☐	☐	☐
Completed Suicide	☐	☐	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐	☐	☐
Other Mental Health Disorder	☐	☐	☐	☐	☐	☐

Physician's Name / Address / Phone: _____

_____

Does your child have any allergies? _____

Is your child currently taking any medications?

Name of Medication	Dosage	Frequency	Reason for Taking	Prescribed by:

For Females - Date of Last Menstrual Period: _____

What medical conditions do you have?

_____

_____

_____

Substance Use History

Do your child have any substance use history? ☐YES ☐NO (if 'YES' complete below)

Is your child currently being prescribed Suboxone? ☐YES ☐NO

Drug Type	Age of first use	Length of use (years)	Date of last use (month/year)	Amount of last usage	Frequency / How much?
Alcohol					
Methamphetamines *					
Amphetamines **					
Barbiturates/Benzodiazepines ***					
Crack/Cocaine					
Marijuana					
PCP ****					
Opiates *****					
Tobacco					
Other					

*Methamphetamines - meth, crank, ice, crystal meth
**Amphetamines (not including cocaine, crack, or methamphetamines) - stimulants, uppers, speed, Ritalin, diet aids, dexedrine, dexamyl, etc.
***Barbiturates (and other depressants, including benzodiazepines) - sedatives, quaaludes, Valium, downers, tranquilizers, elavil, seconal, phenobarbital, etc.
****Opiates - heroin, opium, demerol, pern, codeine, darvon, darvocet, diluadid, OxyContin, and any other opiate except methadone
*****PCP - phencyclidine, angel dust

Family History

Was your child adopted? ☐ YES ☐ NO

Are the child's parents divorced or separated? ☐ YES ☐ NO

Who resides in the home? _____

Developmental History

Was the child full-term? ☐ YES ☐ NO If no, month of gestation when born? _____

Please describe your child's birth. ☐Uneventful ☐ Breech ☐ Cesarean

Did your child reach developmental milestones within expected time range? If not, please explain:

_____

Any alcohol, drugs, or tobacco use during pregnancy? If yes, please list substances used:

_____

Education and Employment

Current school: _____ Grade Level: _____

Grades: ☐ Excellent ☐ Good ☐ Average ☐ Poor

IEP or 504 plan? _____

*** For office use only:**

HT: _____ WT: _____ BP: _____ P: _____