BEARDEN BEHAVIORAL HEALTH / TRINITY MEDICAL
CHILD HISTORY FORM

NAME: _____ **DATE:** _____
DOB: _____ **SEX: MALE FEMALE**

SOCIAL HISTORY:

Does the child have siblings: __Yes __No **If yes, how many**? _____ **Ages**? _____

Are biological parents: __Married __Divorced __Separated

Step-Parent? __Yes __No **Foster parent?** __Yes __No **Adopted parent?** __Yes __No

Who resides in the home? _____

Current grade level: _____ **Grades**: __Excellent __Good __Average __Poor

Does the child get exercise? __Yes __No **If yes, how many days per week?** _____

Do the parents use any form of tobacco in the home(cigarettes, cigars, snuff, chew)? __Yes __No

If yes, which parent? __Mother __Father __Step-parent __Both

Has the child ever smoked or used any form of tobacco? __Yes __No

Has the child ever used illegal drugs? __Yes __No

MEDICAL HISTORY:

Pediatrician / PCP: _____ **Phone Number**: _____

May we exchange information with the Pediatrician / PCP? __Yes __No

CURRENT MEDICATIONS (including Vitamins & OTC)	**DOSE**	**x PER DAY**	**PRESCRIBING DOCTOR**

ALLERGIES OR REACTIONS TO MEDICATIONS: __YES __NO, NO ALLERGIES TO ANY MEDICATIONS

If yes, please list the medication(s), as well as the reaction or side effect:

_____

_____

PERSONAL MEDICAL HISTORY, CONTINUED

PLEASE LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES THE CHILD HAS: _____

_____

_____

PLEASE LIST ANY SURGERIES AND HOSPITALIZATIONS INCLUDING DATE AND REASON:

_____

_____

_____

PLEASE CHECK ALL OF THE FOLLOWING CONDITIONS THE CHILD <u>HAS</u> OR <u>HAS BEEN</u> TREATED FOR:

__Allergies	__Asthma	__Anxiety	__Chicken Pox
__Anemia	__Abnormal EKG	__Acid Reflux	__Frequent Ear Infections
__Blood Clots	__Bleeding Problems	__Transfusion	__Acne
__Diabetes	__Depression	__Dizziness	__Drug abuse
__Drug Overdose	__Eczema/Psoriasis	__Epilepsy/Seizures	__Gallbladder Disease
__Headaches(non-Migraine)		__Hearing Problems	__Heart Defects
__Heart Murmur	__Arrhythmia	__Palpitations	__High Blood Pressure
__Hepatitis	__Learning Disability	__Physical Disability	__High Cholesterol
__Emotional Disorder	__Insomnia	__Kidney Disease	__Irritable Bowel
__Liver Disease	__Leukemia	__Meningitis	__Migraines
__Muscle Disease	__ADD/ADHD	__Panic Attacks	__Obsessive-Compulsive Disorder
__Pancreatitis	__Pneumonia	__Muscle Disease	__Suicide Attempt
__STD	__Sinus Disease	__Thyroid Disease	__Ulcers
__Urinary Infections	__Tuberculosis/ + TB Skin Test		__Emotional or Physical Abuse
__Vision Problems	__Broken Bones	__Sexual Abuse	

__ OTHER _____

FEMALES: Age of first menses: _____ Date of Last Menstrual Period:_____
Does child suffer from PMS? _____

MALES: Testicular Problems: __Yes __No Age of puberty? _____
Other male developmental disorder? __Yes __No

FAMILY HISTORY:

Was child adopted? __Yes __No

Please put a checkmark in all applicable boxes below pertaining to child's family medical history:

ILLNESS	FATHER	MOTHER	SIBLING	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNT/ UNCLE
Heart Disease								
High Cholesterol								
High Blood Pressure								
Diabetes								
Heart Attack								
Stroke								
Kidney Disease								
Liver Disease								
Bleeding or Clotting D/O								
Asthma								
Anemia								
Skin Cancer								
Other Cancer								
Thyroid Disease								
Seizures/ Epilepsy								
HIV/AIDS								
Depression/ Anxiety								
Drug / Alcohol Addiction								
Suicide Attempt								

PREGNANCY & BIRTH HISTORY:

Did the mother have any illnesses during pregnancy? __Yes __No
If yes, list the illness(es): _____

Did the mother take any prescribed medications during pregnancy? __Yes __No
If yes, list the medication(s) taken: _____

Did the mother use/abuse alcohol or drugs during pregnancy? __Yes __No

Did the mother smoke cigarettes or use tobacco during pregnancy? __Yes __No

Were there any other problems during pregnancy? __Yes __No
If yes, please list the other problem(s): _____
_____

Was the child full-term? __Yes __No **If no, month of gestation when born?** _____

Any problems at birth (i.e., jaundice, low birth weight, feeding problems, etc.)? __Yes __No
If yes, please list the problem(s): _____

Were there any other problems during infancy? __Yes __No
If yes, please list the other problem(s): _____
_____