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?
_____
_____
_____
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? _____
_____
_____

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 ? _____

	Yes	Occasionally/ 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: _____

	Yes	Occasionally/ 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:

	Yes	Occasionally/ 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: _____

	Yes	Occasionally/ 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: _____

	Yes	Occasionally/ 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 _____			
_____			
_____			
Has this child had more than his/her share of illnesses or injuries…….	____		____

Child's Name: _____

	Yes	Occasionally/ 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: _____

	Yes	Occasionally/ 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 _____

_____

_____

D. Prescription medications recently discontinued _____

_____

_____

E. Allergies and/or drug reactions _____

_____

_____

F. Hospitalizations (date and reason) _____

_____

_____

G. Present health problems _____

_____

_____

VI. Substance abuse by <u>CHILD</u> (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: _____

_____

_____

(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. _____

_____

_____

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**

_____

_____

(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 _____

_____

_____

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 _____

_____

_____

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. _____

_____

_____

_____

X. Please describe any other helpful information about your child _____

_____

_____

_____

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:

_____

_____

_____

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:

_____

_____

_____

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_____