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Child and Adolescent History Form

Please print and accurately complete every blank on this form.

Patient Name: _____ Date of Birth ___ /___/____
Appointment Date _____
Person Completing Form & Relationship to Patient: _____
A parent or legal guardian **must** accompany his/her child or adolescent to their first appointment.

Custody Papers: If biological parents are divorced, or if patient is adopted or in foster care, please bring the necessary legal documents regarding the child or adolescent patient's legal custody.
The patient will **not** be seen without these documents. Same applies for future custody changes.
Who has custody? Describe any changes in custody and related legal matters:

_____
_____
_____
_____***Additional Blank Sheet of Paper – CIRCLE ARROW***→

What's your reason for coming to see Dr. Cantwell today & how do you hope he can help?

_____
_____
_____
_____
_____
_____
_____
_____ →

Medication Allergies: _____ →

Current Psychiatric Medications: Name/Dose/Directions/Benefit/Side Effects:

_____
_____
_____
_____
_____
_____ →

Current Other Medications: Name/Dose/Directions/Condition Treated:

_____
_____
_____
_____
_____
_____ →

Current Counselor: Name _____ Phone Number_____
Appointment Frequency _____ How long seen? _____
Primary Care Provider: Name _____Phone Number_____
Other Medical Providers Name/Number: _____
_____
_____
_____
_____
_____→

COMPLETE & SIGN A <u>SEPARATE</u> RELEASE OF INFORMATION/MEDICAL RECORD REQUEST FOR ALL

PSYCHIATRIC HISTORY:
Previous psychiatrist name(s), when & how long seen? _____
_____
_____→
Past counselor name(s), when & how long seen? _____
_____
_____→
Prior Psychiatric Hospitalizations or Substance Rehabilitation: Yes ____ No _____
Where, when & how long? _____
_____
_____
_____→
Thoughts of harming others _____, Describe thoughts of harming others _____
_____.
Suicide Attempts: Yes _____ No _____How many times? _____ When was the first? _____
When was last? _____ How did patient attempt? _____
_____→
Other Self Harm: Yes _____ No _____How many times? _____ When was the first? _____
When was last? _____ How did patient harm self? _____→
Psychiatric Diagnoses: _____
_____→
Abuse History: Physical ___, Sexual ___, Emotional ___, (Describe When, What & By Whom)
_____
_____
_____→

SUBSTANCE USE HISTORY:
Tobacco: Yes ____ No ____ How much/how often? _____
Caffeine: Yes ____ No ____ How many per day? _____ What is patient cut off time? _____
Alcohol: Yes _____ No ____ How much/how often? _____
Drugs, including but not limited to marijuana, cocaine, crack, ecstasy, LSD, mushrooms, meth/amphetamines, opiates, benzodiazepines, inhalants, etc.):

List any recreational drugs taken, how often taken, and when was last time?

Past Psychiatric Medications: Name/Maximum Dose/Benefits/Side Effects/How Long Taken

MEDICAL & SURGICAL HISTORY: List ALL Medical Problems & Surgeries in Lifetime

DEVELOPMENTAL HISTORY:
Described any problems or complications related to parent's pregnancy, delivery or newborn period for the patient, including medications, prematurity, emergency C-section, low Apgar Scores, etc.:

Describe medical problems in the first 5 years **not** listed in the Medical & Surgical History above:

Developmental Milestones and Concerns:
Age that patient: Crawled _____ Walked _____ Talked _____ Toilet Trained _____
Describe any abnormalities in Developmental Milestones (Motor, Language, Social):

Describe any developmental problems with eating, growth, sleeping, urination and/or bowels:
_____
_____
_____
_____
_____→
If there is still bedwetting, how often does this occur and describe any related problems?
_____
_____→
If there is still soiling, how often does this occur and describe any related problems?
_____
_____→
Describe where patient sleeps, with whom, as well as problems sleeping with parents/others:
_____
_____ →
Describe any problems separating from parents: _____
_____→

PSYCHOSOCIAL HISTORY:
School History: Current Grade, School and How Long Attended?
_____
Special Education Details (IEP, 504 Plan, Learning Disabilities, Last Triennial Testing ***BRING TO APPT***)
_____
_____→
What have school grades been in the past year? _____
_____→
Describe any behavior problems in school (including detentions, suspensions or expulsions):
_____
_____
_____→
Past Schools and When Attended: _____
_____
_____
_____→
Describe school grades and behavior issues in previous years: _____
_____
_____
_____→
Describe involvement in extracurricular activities, such as sports, clubs, hobbies, and interests:
_____
_____
_____→

Describe past and current peer relationships, such as making and keeping friends, best friends:
_____
_____
_____→
Describe your child's chores and any related problems: _____
_____→
Describe patient's employment: _____ →
Describe how your child is disciplined: _____
_____→
Describe parent/guardians' involvement in discipline and related challenges: _____
_____
_____→
Describe legal problems involving law enforcement: _____
_____→
Describe patient's strengths and weaknesses: _____
_____
_____
_____→
Biologic Mother's Name/Age/Occupation: _____
Biologic Father's Name/Age/Occupation: _____
Are parents married? Yes ___ No ___ How long? _____
Describe any separation(s) and/or divorce(s) that have occurred and the impact on patient:
_____
_____
_____→
Describe details of custodial and living arrangements, including stepparents, relatives, etc.:
_____
_____
_____
_____→
Describe siblings, including how many sisters/brothers, including step and half-siblings, their names, ages, and any problems? _____
_____
_____
_____→
BIOLOGICAL FAMILY HEALTH HISTORY: (Depression, Anxiety, Bipolar, Schizophrenia, Substances, Dementia, ADHD, Learning Disabilities, Thyroid Disorders, Neurologic Disorders, etc.)
_____
_____
_____
_____
_____→

PSYCHIATRIC REVIEW OF SYSTEMS:
Sleep: How long does it usually take to fall asleep? _____
Number of awakenings/night & time to fall back to sleep? _____
Average total hours sleep: Schooldays _____ Off School_____
Describe patient's appetite: _____
Binging/Purging (Describe/Frequency) _____
Weight gain +/loss – (lbs.) _____ in _____ time
Describe patient's energy: _____

CHECK ALL SYMPTOMS THAT APPLY TO YOU IN THE PAST SEVERAL WEEKS TO MONTHS:

Depression: Sad ___, Hopeless ___, Helpless ___, Worthless ___, Guilt ___, Crying___, Indecisive__
Irritability ___, Social Isolation ___, Loss of Motivation ___, Loss of memory/concentration ___,
Loss of interest/pleasure ___, Decreased libido ___, Pessimism ___, Wishing one were dead ___,
Thoughts of Killing Oneself ___, Thoughts of Hurting Oneself ___, What specifically has patient thought about doing to kill or hurt self? _____ →
_____ →
When is the *last time* and *how* did patient try to hurt or kill self? _____
_____ →
Who did patient tell and *what medical treatment* did patient seek for it? _____
_____ →
Does patient regret suicide failure and why? _____
_____ →
Mania: Elevated or Euphoric Mood ___, Rage ___, Excessive/Fast Talking ___, Racing Thoughts ___,
Increased Energy ___, Increased Activity ___, Impulsivity ___, Grandiose Thinking ___,
Increased Libido ___, Spending Sprees ___, Risk Taking ___, Recklessness ___, Invincible ___,
Anxiety: Nervous ___, Excessive Worry ___, Ruminating ___, Muscle tension ___, Avoidant ___,
Overwhelmed ___, Panic ___, Feeling of Doom/Terror ___, Tremor ___, Shortness of Breath ___,
Chest Discomfort ___, Heart Pounding ___, Numbness/Tingling ___, Nervous stomach ___,
Obsessing about weight gain ___, Nightmares ___, Intrusive Thoughts ___, Increased Startle ___,
Flashbacks of Traumatic Events ___, Germ Phobia ___, Excessive Hand Washing ___,
Excessive Orderliness ___, Excessive Cleaning ___, Perfectionistic ___, Compulsive Behaviors/Rituals (Describe)_____ →
Fears of: Leaving Home ___, Being Alone ___, Meeting People ___, Crowds ___, Open Spaces ___,
Fear of Driving ___, Specific Situations/Things (Describe) _____
ADHD: Problems Paying Attention ___, Distractibility ___, Hyperactivity ___, Impulsivity ___
Psychosis: Auditory Hallucinations ___, Visual Hallucinations ___, Others Are Out to Get You ___,
Impaired Reality Testing ___, Things Happen That Usually Refer to You ___,
Someone or Something Outside Controls One's Thinking (Describe) _____→

MEDICAL REVIEW OF SYMPTOMS: Fever ___, Chills ___, Sweats ___, Rash ___, Seizures ___,
Dizziness ___, Fainting Spells ___, Head Trauma w/ or w/out (circle) loss consciousness ___,
Headaches (Describe, Including Frequency, Duration) _____→
Loss of Balance ___, Problems Falling ___, Numbness ___, Extremity Weakness ___, Anemia ___,
Loss of Vision ___, Blurred/Double (circle) Vision ___, Eye/Ear (circle) Pain ___, Glaucoma ___,

Ringing in Ears ___, Hearing Loss ___, Hair loss ___, Heat/Cold (Circle) Intolerance ___,
Thyroid Problem (circle High or Low) ___, Increased Thirst ___, Urinary frequency ___,
Blood Sugar High/Low (Circle) ___, Diabetes ___, Chest Pain ___, Palpitations ___, Calf/leg pain ___,
Swelling ___, Heart Disease ___, High Blood Pressure ___, Short of Breath ___, Wheezing ___,
Coughing ___, Asthma ___, Allergies ___, COPD __, Coughing up blood ___, Abdominal Pain ___,
Swallowing Problems ___, Nausea ___, Vomiting ___, Throwing up blood ___, Blood in stool ___,
Heartburn/Reflux ___, Constipation ___, Diarrhea ___, Urinary Pain ___, Urinary Urgency ___,
Urinary Blood ___, PMS ___, Menses Regular/Irregular (Circle) ___,
LAST MENSTRUAL PERIOD _____ Chronic pain (Describe) _____