

Medical Information for Child or Adolescent

Please print clearly and leaving nothing blank. Thank you.

Name _____ Date of Birth _____ Date _____

Sex M ___ F ___ Religion (optional) _____

School _____ Grade _____

Chief Concern:

Please use initials(C or F) to identify problems or concerns for Child or Other Family members:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> fears | <input type="checkbox"/> shyness | <input type="checkbox"/> loneliness | <input type="checkbox"/> relaxation |
| <input type="checkbox"/> panic attacks | <input type="checkbox"/> separation/divorce | <input type="checkbox"/> guilt | <input type="checkbox"/> legal issues |
| <input type="checkbox"/> friends | <input type="checkbox"/> anger | <input type="checkbox"/> nightmares | <input type="checkbox"/> crying spells |
| <input type="checkbox"/> unhappiness | <input type="checkbox"/> stress | <input type="checkbox"/> stomach/bowel | <input type="checkbox"/> concentration |
| <input type="checkbox"/> headaches | <input type="checkbox"/> tiredness | <input type="checkbox"/> stepfamily | <input type="checkbox"/> fearful |
| <input type="checkbox"/> memory | <input type="checkbox"/> lacks initiative | <input type="checkbox"/> making decisions | <input type="checkbox"/> finances |
| <input type="checkbox"/> energy | <input type="checkbox"/> grief | <input type="checkbox"/> withdrawn | <input type="checkbox"/> sexual |
| <input type="checkbox"/> temper | <input type="checkbox"/> temper outbursts | <input type="checkbox"/> low self-esteem | <input type="checkbox"/> drugs |
| <input type="checkbox"/> self-control | <input type="checkbox"/> certain thoughts | <input type="checkbox"/> suicidal | <input type="checkbox"/> daydreaming |
| <input type="checkbox"/> clumsy | <input type="checkbox"/> slow | <input type="checkbox"/> short attention span | <input type="checkbox"/> distractible |
| <input type="checkbox"/> undependable | <input type="checkbox"/> peer conflict | <input type="checkbox"/> impulsive | <input type="checkbox"/> stubborn |
| <input type="checkbox"/> disobedient | <input type="checkbox"/> infantile | <input type="checkbox"/> mean to others | <input type="checkbox"/> destructive |
| <input type="checkbox"/> running away | <input type="checkbox"/> self-mutilating | <input type="checkbox"/> head banging | <input type="checkbox"/> rocking |
| <input type="checkbox"/> shy | <input type="checkbox"/> fire setting | <input type="checkbox"/> stealing | <input type="checkbox"/> lying |
| <input type="checkbox"/> school performance | <input type="checkbox"/> truancy | <input type="checkbox"/> bed wetting | <input type="checkbox"/> soiled pants |
| <input type="checkbox"/> eating problems | <input type="checkbox"/> sickly | <input type="checkbox"/> irritable | |

How long have these problems occurred? (number of weeks, months, years) _____

What happened that makes you seek help at this time? _____

Is this problem ___ mild ___ moderate ___ severe?

Does this problem affect ___ school ___ relationships ___ health ___ other _____

Have there been recent changes in ___ weight ___ appetite ___ sleep ___ health ___ other

Please describe _____

Anxiety ___ mild ___ moderate ___ severe

Depression ___ mild ___ moderate ___ severe

Current Family Situation

Please name all those living in your home (start with your child)

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Description</u>
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

Name _____ Date _____

If parents are divorced and child moves between more than one home, please describe the current arrangement:

Mother – relationship to child ___ natural parent ___ relative ___ guardian
 ___ step-parent ___ adoptive parent

Mother's name _____ Mother's occupation _____

Education _____ Religion _____

D.O.B. ___ Age _____ Culture _____

Mother's Best # to reach _____ Address _____

Father – relationship to child ___ natural parent ___ relative ___ guardian
 ___ step-parent ___ adoptive parent

Father's name _____ Father's occupation _____

Education _____ Religion _____

D.O.B. ___ Age _____ Culture _____

Father's Best # to reach _____ Address _____

Marital History of Parents:

___ Married when _____ age _____
___ Separated when _____
___ Divorced when _____
___ Never married
___ Deceased M or F _____ when _____

Step-parents mother remarried when _____ to whom _____

Step-parents father remarried when _____ to whom _____

Health of Family Members: (excluding patient, patient will be covered later)

Name relationship to child type of illness when occurred length of illness

1. _____
2. _____
3. _____

Does or did any member of the child's family have problems with:

___ reading ___ spelling ___ math ___ speech

Is there any history in the child's family of:

___ mental retardation ___ epilepsy ___ birth defects ___ schizophrenia

Name _____ Date _____

Child Health Information:

Note all health problems the child **has had** or **has now**

	<u>Age</u>		<u>Age</u>
<input type="checkbox"/> High fevers	___	<input type="checkbox"/> Dental Problems	___
<input type="checkbox"/> Pneumonia	___	<input type="checkbox"/> Weight problems	___
<input type="checkbox"/> Flu	___	<input type="checkbox"/> Allergies	___
<input type="checkbox"/> Encephalitis	___	<input type="checkbox"/> Skin problems	___
<input type="checkbox"/> Meningitis	___	<input type="checkbox"/> Asthma	___
<input type="checkbox"/> Convulsions	___	<input type="checkbox"/> Headaches	___
<input type="checkbox"/> Unconsciousness	___	<input type="checkbox"/> Stomach problems	___
<input type="checkbox"/> Concussions	___	<input type="checkbox"/> Accident prone	___
<input type="checkbox"/> Head injury	___	<input type="checkbox"/> Anemia	___
<input type="checkbox"/> Fainting	___	<input type="checkbox"/> High or low blood pressure	___
<input type="checkbox"/> Dizziness	___	<input type="checkbox"/> Sinus problems	___
<input type="checkbox"/> Tonsils out	___	<input type="checkbox"/> Heart problems	___
<input type="checkbox"/> Vision problems	___	<input type="checkbox"/> Hyperactivity	___
<input type="checkbox"/> Hearing problems	___	<input type="checkbox"/> Other illnesses, ect.	___
<input type="checkbox"/> Earaches	___		

Has child ever been hospitalized? Yes No explain _____

Please list any known medical conditions your child has and medications taking for them:

<u>Medical concern</u>	<u>Medication</u>	<u>Dosage</u>	<u># times per day</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____

Educational History:

Types of classes: regular learning disability
 emotionally handicapped gifted

Did child skip a grade? Yes No Repeat a grade? Yes No

If yes, please describe _____

Did your child have specific learning issues? _____

Describe your child's report card (strengths and weaknesses): _____

Does your child participate in extracurricular activities? Yes No

Describe _____

Has your child had special testing in school? Yes No
Psychological Yes No Vocational Yes No

Testing for learning issues? Yes No

What were the results? _____

Name _____ Date _____

Developmental History:

Normal pregnancy Yes No explain _____

Length of pregnancy _____

Full term yes no

If premature, how early? _____

If over due, how late? _____

Birth weight: _____ lbs. _____ oz.

Type of delivery: spontaneous cesarean with instruments
 head first breech

Was it necessary to give infant oxygen? yes no If yes, how long _____

Did infant require blood transfusion? yes no

Did mother use alcohol, medication or drugs during pregnancy? yes no

Newborn period:

	<input type="checkbox"/> yes	<input type="checkbox"/> no	How long?
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions/twitching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Normal weight gain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was child breast fed?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Developmental milestones: (age these occurred)

Sat up: _____
 Crawled: _____
 Walked: _____
 Spoke single words: _____
 Sentences: _____
 Bladder trained: _____
 Bowl trained: _____
 Weaned: _____

Describe special habits, fears, or idiosyncrasies of the child:

Prior Mental Health Treatment:

Please describe any prior counseling your child has had (include dates and name of therapist if possible):

Name _____ Date _____

Past and present prescribed psychiatric medications (including sleep aids, over the counter products, herbals)

<u>Name</u>	<u>By Whom</u>	<u>Dose</u>	<u>How long</u>	<u>Results</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list all recreational drugs your child has used or experimented with: (Please include alcohol and nicotine)

<u>Drug name</u>	<u>When (ages)</u>	<u>How long (how many times)</u>	<u>Amount/Frequency</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is your child's Physician? _____ Phone _____

Address _____

Current stressors in your child's life:

Please describe any changes that are currently or recently gone on within your child's life or family's life.

What goals would you like to see achieved in counseling? _____

Thank you for taking the time to complete this lengthy form. It is very useful to have this background information on your child to assist in providing the best care we can deliver. You are invited to update it as needed.

Signature of person completing the form

2/24/03, 4/11

Date