

Child/Adolescent History Form

Date: _____ Doctor/Therapist: _____

Child's Name: _____ Age: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Ethnicity: _____ Gender: Male Female

Name of person accompanying client today: _____ Relationship: _____

Mother's Name: _____ Age: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Single Married Separated Divorced Remarried Widowed

Name of Mother's Spouse or Partner (if applicable): _____

Father's Name: _____ Age: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Single Married Separated Divorced Remarried Widowed

Name of Father's Spouse or Partner (if applicable): _____

If parents are divorced/separated, who has legal custody of child? Mother Father Joint Other

Please list siblings, parents, stepparents, etc.

Name:	Relationship:	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School child is currently attending: _____ Grade: _____

Name of Primary Teacher: _____

Referred By: Self Hospital Family/Friend School Court
 Physician CPS Other _____

Reason for Referral: Mental Health Substance Abuse Zero Tolerance

Briefly describe the problem that brings this child/adolescent to BGPS today:

Please check the behaviors observed:

- | | |
|--|---|
| <input type="checkbox"/> Depression/sad thoughts | <input type="checkbox"/> Anxiety/nerves |
| <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Compulsive behaviors |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Social withdrawal | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Too much energy |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Aggression/violence |
| <input type="checkbox"/> Running away | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Poor attention | <input type="checkbox"/> Seeing visions |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Other(s): _____ |

Has the child/adolescent had mental health treatment before? Yes No

If yes, when and where? _____

Has the child/adolescent had treatment for drug use before? Yes No

If yes, when and where? _____

Has the child/adolescent had any legal involvement? Yes No

If yes, please explain: _____

Has the child/adolescent been involved with DHS? Yes No

If yes, please explain: _____

Does the child/adolescent have any current or ongoing medical problems? Yes No

If yes, please explain: _____

Who is the child/adolescent's primary care physician? _____

What medications does the child/adolescent take? (include non-prescription, herbal meds, & supplements)

Medicine	Dose	Frequency	Who prescribes medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What pharmacy do you use? _____ Phone: _____

Please list any allergies, including medication allergies/sensitivities:

Signature of Parent completing form: _____

Witnessed by: _____