becker/gibeau

Child/Adolescent History Form

Doctor/Therapist: _____ Date: _____

Child's Name: _____ Age: _____ Birthdate: _____
Child's Gender: ☐ Male ☐ Female

Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Ethnicity: _____

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

School child is currently attending: _____
Grade: _____ Name of Primary Teacher: _____

Referred By: ☐ Self ☐ Hospital ☐ Physician ☐ CPS

Reason for Referral:
☐ Mental Health ☐ Family/Friend ☐ School ☐ Court ☐ Substance Abuse ☐ Zero Tolerance
☐ Other _____

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

Please check the behaviors observed

☐ Depression/sad thoughts	☐ Poor concentration	☐ Compulsive behaviors	☐ Memory problems
☐ Thoughts of suicide	☐ Poor attention	☐ Stealing	☐ Running away
☐ Weight loss/gain	☐ Distractibility	☐ Racing thoughts	☐ Paranoia
☐ Sleep problems	☐ Hyperactivity	☐ Too much energy	☐ Hearing voices
☐ Social withdrawal	☐ Anxiety/nerves	☐ Anger	☐ Seeing visions
☐ Irritability	☐ Panic attacks	☐ Aggression / violence	☐ Blackouts
☐ Low energy			

Other: _____

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? _____ Pharmacy Phone: _____

Please list any allergies, including medication allergies/sensitivities:

_____ _____

Signature of Parent completing form Date

_____ _____

Witnessed by Date