Mental Health History for Children and Adolescents

The following questions are designed to be of assistance in determining the needs of your child or adolescent. Please complete this questionnaire as accurately and honestly as possible. Please print legibly. All of the information which you provide will be treated confidentially.

Date: _____

Name **of Insurance Subscriber**:_____
Social Security # of **Insurance Subscriber**: _____
Employer of **Insurance Subscriber:** _____
Insurance Plan: _____

Did someone refer you to my practice? Yes ____ No _____
If yes, who referred you? _____
What was the reason? _____

Patient's Name _____ DOB_____
Patient's Social Security #: _____
Address:_____
City/State/Zip:_____

Mother's Name_____ DOB_____
Father's Name_____ DOB_____
Step-Parent's Name_____ DOB_____
Step-Parent's Name_____ DOB_____

Who has legal custody of the child:_____

Parents with whom the child lives:

Name	Age	Education	Relation to Child	Occupation
_____	___	_____	_____	_____
_____	___	_____	_____	_____

Others **Living in the home:**

Name	Age	Sex	Education	Relationship to Child	Problems

List Sibling's **not living at home:**

Name	Age	Sex	Education	Relationship to Child	Problems

If either parent is not living in the home, please provide the following information:

Name:_____ Age:_____
How often seen by child:_____
Where living:_____
Problems:_____
_____

Educational History:

At what age did you child enter Day Care: _____
Did your child attend Pre-School: _____
At what age did your child enter school:_____
Did you child ever repeat a grade: _____
Does your child like school: _____
Does your child have any learning problems or receive special help:
_____
What is your child's favorite subject: _____
Does the teacher report any problems: _____ If yes, please explain
_____

Current School_____ Grade_____

Please list all the schools your child has attended until present:

_____

_____

_____

Please describe your child's last report card:

_____

_____

Type of Placement: Regular L.D. S.L.D. E.H. E.M.H. Gifted Special/Regular

Has psychological testing been completed? Yes____ No____ by whom? _____
Has educational testing been completed? Yes ___ No ____ by whom? _____

If yes for above, please discuss providing these test results to the therapist. The results can be instrumental in the treatment process.

Please indicate the behaviors that are a source of concern for you. Indicate **P for past** and **C for current**:

__Changes mood frequently
__Demands too much attention
__Does poorly in school
__ Shy
__Excitable
__Jealous of siblings
__Grinds teeth
__Won't obey
__Bullying, cruel
__Temper tantrums
__ Steals
__ Fearful
__ Bed wetting
__ Impulsive
__ Alcohol use
__ Cigarette smoking
__ Eating problems
__Worry/anxiety
__ Other _____

__Can't concentrate/sit still
__Doesn't have any friends
__Speech problem/stutters
__Blames others for own mistakes
__Childish, immature
__Fails to finish things
__Has headaches often
__Sets fires
__Runs away from home
__ Withdrawn
__ Day dreaming
__ School performance
__ Peer issues
__ Drug use
__ Head banging
__ Trouble with the law
__Sad/depressed
__ Sexually acting out

__Breaks things on purpose
__Feels worthless/no good
__Has stomach aches often
__Is awkward/poor coordination
__Cries or whines a lot
__Sucks thumbs
__Has trouble going to sleep
__Lies
__Has no energy
__Skips school
__ Irritable, easily frustrated
__ Short attention span
__ Soiled pants
__ Suicide talk
__ Defiant
__ Sexual abuse
__ Compulsive
__ Pregnancy

<u>Medical History</u>:

Name of Pediatrician:_____
Address of Pediatrician: _____
Phone #: _____

Has child ever had a fever over 105 degrees F:_____
Has child ever had a seizure: _____

List all medical hospitalizations:

Reason	Dates

Chronic Illness/ head injuries:

Reason	Dates

List of medications for medical or mental health issues (present and past):

Medication	Dosage

Previous Mental Health Treatment: Yes_____ No_____

Out-patient Counseling:

Date	Therapist/Psychiatrist

In-patient Counseling:

Date	Facility	Therapist/Psychiatrist

In-school Counseling:

Date	School	Grade	Therapist/Psychologist

Has any **blood** relative of this child ever had the following:

	Yes	No
Hyperactivity	___	___
Learning problems in school	___	___
Mental retardation	___	___
Epilepsy	___	___
Behavior problems in school	___	___

Depression	___	___
Problems with alcohol or other drugs	___	___
Juvenile police record	___	___
Adult police record	___	___
Outpatient psychiatric care	___	___
Inpatient psychiatric care	___	___
Prescription of tranquilizers or anti-depressants	___	___

Prenatal History:

Prenatal Care: Yes_____ No_____ Full Term: Yes____ No____
If premature, how early:_____ Birth weight: _____lbs. _____oz.
Were there problems during delivery: ___Yes ___No If yes, explain
_____
Type of delivery: ____ spontaneous _____ cesarean _____ with instruments (forceps) ____head first _____breech
Was the baby kept in an incubator: _____
Was labor induced by medicine: _____
Was any medicine taken by the Mother: _____
Was pregnancy toxemic:_____
Was it necessary to give the infant oxygen: _____
Was the infant discharged with Mother: _____
Did mother use alcohol/drugs/nicotine during pregnancy? _____
If yes, please explain: _____
_____

Developmental History:

Was baby breast fed:_____ or regular formula _____
When was baby weaned:_____
Difficulty Sleeping as an infant ____ Colic _____ First crawled ____(age)
Sat up ____(age) Walked ____ (age) Spoke full sentences____ (age)
Stayed dry all day ____(age) Stayed dry all night ____(age)
Toilet trained____ (age) First spoke words ____(age)

Social Development:

Did child have any friends before entering school: _____
Does child get along with others: _____
Does child have one best friend: _____
Does child get along well with adults: _____
Does child get along well with brothers and sisters: _____
What does child like to do for fun: _____
_____

Emotional Development:

Does child refuse affection: _____
Did child refuse affection as an infant:_____
Does child refuse to give affection: _____
Are child's feelings easily hurt: _____
Does child get angry easily: _____
Does child seem not to care about the feelings of others: _____

Goals of therapy:

What would like to see happen as a result of therapy:

_____
_____
_____
_____
_____
_____

Is there any other information that you believe would be helpful for the therapist to know?

_____
_____
_____
_____
_____

What are three things that **you like best** about your child:

_____
_____
_____

I understand that this information is being provided to my child's mental health therapist only. It is my responsibility to share relevant medical information with my child's Pediatrician/Primary Care Physician.

_____
Name of the person completing this questionnaire Date

_____
Therapist's Signature Date