Child/Adolescent New Client-Medical and Behavioral Health History

Name_____ Preferred Name_____ Today's Date_____

Date of Birth: _____ Age: _____ Ethnicity _____

- ❑ Male
- ❑ Female
- ❑ Transgender
- ❑ Other

Have you been referred to this office by anyone? _____

Reasons for seeking mental health services: _____

_____

INFORMATION ABOUT THE CHILD AND FAMILY

Child's Sex: Male_____ Female_____

Mother's Name: _____ Age: ____ Occupation_____

Father's Name: _ _____ Age: ____ Occupation_____

Mother completed: High school_____ Some College_____ College Graduate_____

Father completed: High school_____ Some College_____ College Graduate_____

Parents are: Married_____ Divorced_____ Separated_____ Never Married_____

Child Currently lives with:_____

Child's legal guardian(s):_____

Other children in the family: _____

NAME	AGE	List any problems or special needs
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there other people in the home? YES_____ NO_____

What is their relationship to your child?_____

_____

Are there pets in your home? YES_____ NO_____ Please list: _____

Do you live in: Apartment_____ Mobile Home_____ House _____

What is your child's current diagnosis? _____

_____

Who made this diagnosis, and at what age were they diagnosed?

_____

_____

Has your child seen a therapist? (Who, when) _____

_____

Has your child ever been in a Psychiatric Hospital before?

_____

_____

Has your child ever been in partial or residential treatment before? _____

_____

CURRENT LEGAL STATUS

- ❑ Independent Adult
- ❑ Juvenile Dependent of Court
- ❑ Child in custody of biological Parent(s), Adoptive parents(s)
- ❑ Emancipated Minor
- ❑ Juvenile Ward of the Court (Probation 602)
- ❑ Other _____

HAS YOUR CHILD HAD PROBLEMS OR BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

(Check the boxes; if so, note details below.)

- ❑ Feeling sad or hopeless; frequent crying
- ❑ Irritability
- ❑ Often thinking about death/loss
- ❑ Thoughts of suicide
- ❑ Feeling anxious/nervous/worried
- ❑ Having panic attacks
- ❑ Vision/hearing problems
- ❑ Seeing/hearing/feeling things that aren't real
- ❑ Change in appetite
- ❑ Picky eating
- ❑ Weight loss or concern with body image
- ❑ Binge eating/purging or restricting diet
- ❑ Difficulty falling asleep or staying asleep
- ❑ Nightmares/night terror/sleepwalking
- ❑ Snoring or difficult breathing while asleep
- ❑ Excessive daytime sleepiness
- ❑ Bedwetting
- ❑ Daytime toileting accidents
- ❑ Tics/Tourette's, involuntary movements
- ❑ Languages/speech delay

- ❑ Learning disorder (reading/math/writing)
- ❑ Pulling out hair/eyelashes or picking at skin
- ❑ Having few friends
- ❑ Being bullied (physically, verbally, online)
- ❑ Victim of neglect or physical/sexual abuse
- ❑ Excessively rigid adherence to routine
- ❑ Problems transitioning between activities
- ❑ Social withdrawal
- ❑ Hyperactivity
- ❑ Impulsivity
- ❑ Being disorganized/forgetful
- ❑ Difficulty finishing tasks/projects
- ❑ Temper outbursts
- ❑ Aggressive behavior at home
- ❑ Aggressive behavior at school
- ❑ Truancy
- ❑ Police/legal difficulties
- ❑ Excessive use of computer/phone/gaming
- ❑ Use of alcohol or street drugs
- ❑ Witnessed domestic violence
- ❑ Parental divorce
- ❑ Family move
- ❑ Loss of pet
- ❑ Loss of friendship or romantic relationship
- ❑ Parental abandonment
- ❑ Death of family member/friend
- ❑ Any other problems?

Details (age, brief description) for any problems checked above: _____

_____

_____

_____

RISK ASSESSMENT:

Past danger to self (intent, plans, means); self-harm behavior:

_____

_____

Past Danger to others (intent, plan, means):

_____

_____

Additional risk factors: (check all that apply, and document details in comments):

- ❑ Family history of suicide
- ❑ History of domestic violence
- ❑ Sexual abuse
- ❑ Trauma or loss in family
- ❑ Physical abuse/emotional abuse
- ❑ Inappropriate sexualized behavior
- ❑ Impulsivity/threatening behavior
- ❑ Animal cruelty
- ❑ Fire Setting
- ❑ Substance abuse
- ❑ Self-injurious behavior
- ❑ Access to firearms (family, friends)

_____

_____

_____

CHILD'S PRE-BIRTH AND DELIVERY HISTORY:

Was delivery at full term? _____

_____

Problems or illness during pregnancy? _____

_____

Exposed to medications (other than vitamins) during the pregnancy? _____

_____

Maternal substance use (drugs/alcohol/tobacco) or toxic exposure during pregnancy? _____

_____

Difficult delivery?_____

C-section? _____

Birth weight? _____

Did the baby have problems breathing? _____

Was oxygen administered? _____

Jaundice? _____

Blood transfusion? _____

AT WHAT AGE (MONTHS, YEARS) DID THIS CHILD FIRST:

Sit up unsupported? _____

Crawl? _____

Stand alone? _____

Walk? _____

Speak first words? _____

Speak in complete sentences? _____

Complete toilet training?_ _____

Who is your child's/ adolescent's pediatrician or primary care provider?

_____

Are your child's immunizations updated? _____

Allergies? _____

_____

Surgeries?_____

_____

Hospitalizations?_____

_____

Has your child ever had done any of the following?

- ❑ EEG (brain tracing)
- ❑ EKG (heart tracing)
- ❑ MRI (brain scan)
- ❑ Echocardiogram)

❑ Others?_____

CHILD'S GENERAL HEALTH HISTORY (REVIEW OF SYSTEMS): circle which apply**:**

Cerebral palsy	seizures	fainting
Loss of consciousness	Head injury	Hearing problems
Vision problems	Heart disease	Heart murmur
Rheumatic fever	Heart surgery	Blood transfusion
anemia/sickle cell disease	Excessive bleeding	Excessive bruising
Prone to infections	Immune system disorder	AIDS/HIV
pneumonia	Cystic fibrosis	asthma
Difficulty breathing	Stomach or intestinal problems	hepatitis
jaundice	UTI	Bladder or kidney problems
Bed wetting	Possibly pregnant	Diabetes
Thyroid/glandular disorder	Weight loss/gain	Skin problems
Cold sores	Canker sores	Limit use of arms/legs
arthritis/joint problems	Muscle weakness	Others

If you circled any of the above, please explain:

_____

_____

_____

_____

ANY CURRENT OR PAST MEDICATIONS:

Medication Name	Age when used	Dose	Reason	Effectiveness

EDUCATION:

Current School?_____

Grade?_____

Main Teacher?_____

Current Grades (range)_____

Problems with specific subjects?_____

_____

Disciplinary issue?_____

_____

Repeat a grade?_____

Special education needs, such as IEP or 504 plan?_____

_____

Number of schools attended?_____

HAVE YOUR CHILD/ADOLESCENT EXPERIENCED :

- ❑ Physical Abuse
- ❑ Verbal Abuse
- ❑ Emotional abuse
- ❑ Sexual abuse

SUBSTANCE ABUSE HISTORY:

Does your child/adolescent or has he/she ever used drugs or alcohol?

_____

_____

Check which apply:

- ❑ Alcohol
- ❑ Cigarettes
- ❑ Marijuana
- ❑ Diet Pills
- ❑ Crystal meth
- ❑ Inhalants
- ❑ Cocaine/crack
- ❑ Heroin
- ❑ Acid
- ❑ Downers
- ❑ Over-the-counter medications
- ❑ Any others?

FAMILY HISTORY OF MENTAL ILLNESS

	Relative(s)	Brief Description
Alcohol or other substances		

Anxiety, phobias, obsession		
Autism/Asperger's		
Behavioral problem/ conduct/disorder/criminal behavior		
Conflict with family or others		
Depression		
Learning disorders or intellectual difficulties		
Mania/bipolar disorder		
Attention-deficit/hyperactivity disorder		
Psychosis/schizophrenia		
Seizures/epilepsy/traumatic brain injury		
Suicide or suicide attempt/ psychiatric hospitalization		
Tics/Tourette's		
Others		

FAMILY MEDICAL HISTORY

Anyone in the Family Have:

Disorder	Who
Diabetes	
High Blood Pressure	
Heart Disease	
Tuberculosis	
Respiratory	
Hepatitis	
Seizure Disorder	
Cancer	
Kidney Disease	
Thyroid Disease	
Blood Disorder	

Arthritis	
Legal Problems	
Dementia	
Strokes or others	

Is the family currently undergoing any stress, such as illness, death, military deployment, financial problems, multiple moves, job loss? If so, please describe:

If you would like to add anything, please do so in the space below:

Thank you for completing this questionnaire. We hope that the information you have provided will help us to better understand your child/adolescent and provide your family with the best care.

Northland Health Centers